DME MAC Jurisdiction A Resource

FOCUSED INFORMATION for MEDICARE DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, & VT

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Number 9

Delay of the DMEPOS Competitive Bidding Program

(CMS Message 2008-07-16)

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. **This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.** Items that had been included in the first round of the DMEPOS Competitive Bidding Program can be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule.

Additional guidance regarding this new law can be found in the "*Competitive Bidding*" section of this Bulletin and on the DME MAC A Web site.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

This bulletin should be shared with all healthcare practitioners and managerial members of the physician/supplier staff. Bulletins are available at no cost from our Web site at: **www.medicarenhic.com/dme/**

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Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) (MM6048) (SPE)

MLN Matters Number: MM6048 - Revised
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R91NCD
Related Change Request (CR) #: 6048
Effective Date: March 13, 2008
Implementation Date: August 4, 2008

Note: *This article was revised on July 28, 2008, to reflect changes to CR 6048, which CMS revised on July 25, 2008. The CR release date, transmittal number, and the Web address for accessing CR6048 were revised. All other information remains the same.*

Provider Types Affected
Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Durable Medical Equipment (DME) MACs) for OSA-related services provided to Medicare beneficiaries.

Impact on Providers
Providers need to be aware that effective for claims with dates of service on and after March 13, 2008, Medicare will allow for coverage of CPAP therapy based upon a positive diagnosis of OSA by home sleep testing (HST), subject to the requirements of CR6048.

Background
The Centers for Medicare & Medicaid Services (CMS) reconsidered its 2005 National Coverage Determination (NCD) for CPAP Therapy for OSA to allow for coverage of CPAP based upon a diagnosis of OSA by HST.

Medicare previously covered the use of CPAP only in beneficiaries who had been diagnosed with moderate to severe OSA when ordered and prescribed by a licensed treating physician and confirmed by polysomnography (PSG) performed in a sleep laboratory in accordance with section 240.4 of the *Medicare NCD Manual* (see the *Additional Information* section of this article for the official instruction and the revised section of the NCD). Following the reconsideration of its coverage policy, CMS is revising the existing NCD on CPAP therapy for OSA as well as allowing coverage of CPAP based on a positive diagnosis of OSA by HST, subject to all the requirements of the new NCD, as outlined in CR6048. (Note that billing guidelines for capped rental equipment are contained in the *Medicare Claims Processing Manual*, Chapter 20, Section 30.5, which is available at **http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf** on the CMS Web site.)

As part of the NCD, apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation. The apnea hypopnea index (AHI) is equal to the average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

Key Points of CR6048
1. Coverage of CPAP is initially limited to a 12-week period for beneficiaries diagnosed with OSA as described below. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improves as a result of CPAP during this 12-week period.

   Note: *DME Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are required to provide beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively. 42 CFR 424.57(c)(12). Failure to meet this standard may result in revocation of the DMEPOS supplier's billing privileges. 42 CFR 424.57(d).*

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:
   - Polysomnography (PSG) performed in a sleep laboratory; or
   - Unattended home sleep monitoring device of Type II; or
   - Unattended home sleep monitoring device of Type III; or
   - Unattended home sleep monitoring device of Type IV, measuring at least 3 channels

   Note: *In general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary's treating physician are not considered reasonable and necessary. Pursuant to 42 CFR 410.32(b), diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.*

3. A positive test for OSA is established if either of the following criteria using the Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) is met:
   - AHI or RDI greater than or equal to 15 events per hour, or
   - AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

   Note: *The AHI is equal to the average number of episodes of apnea and hypopnea per hour. The RDI is equal to the average number of respiratory disturbances per hour.*

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.

5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.

6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the *NCD Manual* revision attached to CR6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at section 310.1 of the *NCD Manual* and chapter 32 and sections 69.6-69.7 (Pub 100-04) of the *Medicare Claims Processing Manual.* These manuals are available at **http://www.cms.hhs.gov/manuals/IOM/list.asp** on the CMS Web site.

   Note: *The following HST portable monitoring G codes effective March 13, 2008, are provided for your information only, are not included in the CPAP for OSA NCD at section 240.4 of the NCD Manual, and do not necessarily convey coverage, which is determined at local contractor discretion.*

   G0398: Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.
   G0398 Short Descriptor: Home sleep test/type 2 Porta

   G0399: Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
   G0399 Short Descriptor: Home sleep test/type 3 Porta

   G0400: Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels
   G0400 Short Descriptor: Home sleep test/type 4 Porta

Additional Information
To see the official instruction (CR6048) issued to your Medicare A/B MAC, FI , carrier, or DME MAC visit **http://www.cms.hhs.gov/Transmittals/downloads/R91NCD.pdf** on the CMS Web site.

If you have questions, please contact your Medicare A/B MAC, FI, carrier, or DME MAC at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

CR 5971 Clarification - Signature Requirements (SE0829) (GEN)

MLN Matters Number: SE0829
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: 5971
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians and other providers who bill Medicare Contractors (Carriers, Fiscal Intermediaries, Regional Home Health Intermediaries, Part A/B Medicare Administrative Contractors, including Durable Medical Equipment Medicare Administrative Contractors) for care provided to Medicare beneficiaries.

What You Need to Know
The purpose of this notice is to provide guidance to providers/suppliers and Medicare contractors on the use of stamped signatures. **Note that stamped signatures are not acceptable on any medical record.**

Background
The Centers for Medicare & Medicaid Services (CMS) has taken this step to ensure accurate application of Medicare's program requirements throughout the nation. CMS has identified problems of noncompliance with existing statutes, regulations, rules, and other systematic problems relating to standards of practice for a valid physician's signature on medical orders and related medical documents.

CR 5971 (Transmittal #248) was issued to prohibit the use of stamped signatures. These requirements are intended to apply all providers/suppliers. *Stamped signatures are not acceptable on any medical record.* Medicare will accept hand written, electronic signatures or facsimiles of original written or electronic signatures.

In addition, the Medicare Conditions of Participation (CoP) are requirements for ensuring health and safety. The CoPs define specific quality standards that providers must meet to participate in the Medicare program. A provider's compliance with the CoPs is ultimately determined by the CMS regional office based on the State survey agency recommendation (per the *Medicare Program Integrity Manual*, Publication 100-8, chapter 3, section 3.4.2.1, which is available at **http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf** on the CMS Web site). Compliance with the CoPs and any related policies does not necessarily ensure that certain requirements for payment are being met.

Additional Information
The official instruction, CR 5971, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R248PI.pdf** on the CMS Web site.

If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

Reopenings are to correct processing or clerical errors. Medical necessity denials must be handled through the redetermination process.

Implementation of a New Claim Adjustment Reason Code (CARC) No.213. "Non-compliance with the physician self-referral prohibition legislation or payer policy" (MM6131) (GEN)

MLN Matters Number: MM6131
Related CR Release Date: August 15, 2008
Related CR Transmittal #: R1578CP
Related Change Request (CR) #: 6131
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC), regional home health intermediaries (RHHI), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know
CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs (effective January 1, 2009) to use the new Claim Adjustment Reason Code (CARC) #213 when denying claims based on non-compliance with the physician self-referral prohibition.

Make sure that your billing staffs are aware of this new CARC code.

Background
Unless an exception applies (as referenced below), Section 1877 of the Social Security Act (the Act), prohibits a physician from referring a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or his/her immediate family member(s)) has a financial relationship. A "financial relationship" includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements).

The following services are DHS:

- Clinical laboratory services;
- Radiology and certain other imaging services (including MRIs, CT scans and ultrasound);
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Orthotics, prosthetics, and prosthetic devices;
- Parenteral and enteral nutrients, equipment and supplies;
- Physical therapy, occupational therapy, speech-language pathology services;
- Outpatient prescription drugs;
- Home health services and supplies; and
- Inpatient and outpatient hospital services.

Section 1877 of the Act also prohibits the DHS entity from submitting to Medicare, the beneficiary, or any entity for DHS, claims that are furnished as a result of a prohibited referral.

Note: *Violations of this statute are punishable by: 1) Denial of payment for all DHS claims; 2) Refunds of amounts collected for DHS claims; and 3) Civil money penalties for knowing violations of the prohibition.*

Prior to the publication of the new CARC #213 ("Non-compliance with the physician self-referral prohibition legislation or payer policy"), there was no specific code to describe claims that are denied based on "Stark" (the physician self-referral statute at Section 1877 of the Act). Therefore, so that both the DHS providers and the industry will know that claims are being denied because of non-compliance with the physician self-referral prohibitions; CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs to use the new CARC No. 213 (effective January 1, 2009) when denying claims based on non-compliance with the physician self-referral prohibition.

Your Medicare contractors will use this code any time they deny a claim because a physician (or one or more of their immediate family members) has a financial interest in a DHS provider and fails to meet one of the exceptions referenced below.

Exceptions
Please note that the statute enumerates various exceptions, including exceptions for physician ownership or investment interest in hospitals and rural providers. You can read these exceptions in Section 1877 of the Social Security Act Sec. 1877 which you can find at **http://www.cms.hhs.gov/PhysicianSelfReferral/Downloads/section_1877.pdf** on the CMS Web site; and in 42 C.F.R. Part 411, Subpart J.) (42 U.S.C. Section 1395nn).

Additional Information
You can find more information about CARC #213 by going to CR 6131, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1578CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) Web site. You will find the updated *Medicare Claims Processing Manual* Chapter 1 (General billing requirements Section 180 (Denial of Claims Due to Violations of Physician Self-Referral Prohibition) as an attachment to that CR.

If you have any questions, please contact your carrier, FI, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCentertollNumDirectory.zip** on the CMS Web site.

July 2008 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM6049) (DRU)

MLN Matters Number: MM6049
Related CR Release Date: June 6, 2008
Related CR Transmittal #: R1529CP
Related Change Request (CR) #: 6049
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Provider Types Affected
All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What You Need to Know
CR 6049, from which this article is taken, instructs Medicare contractors to download and implement the July 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised April 2008, January 2008, January 2007, April 2007, July 2007, and October 2007 files.

Background
Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs has been performed by the local contractor.

Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs (that both independent and hospital-based ESRD facilities furnish), as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), are paid based on the ASP methodology.

The ASP methodology is based on quarterly data that drug manufacturers submit to the Centers for Medicare & Medicaid Services (CMS), which CMS then provides (quarterly) to Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this

requirement, CMS has also reviewed how the terms "single source drug," "multiple source drug," and "biological product" have been operationalized in the context of payment under section 1847A.

For the purpose of identifying "single source drugs" and "biological products" subject to payment under section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

- The FDA approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003; or
- A single source drug (a drug for which there are not two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of "not otherwise classified, (NOC)" HCPCS codes.

ASP Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities); and
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the OPPS.

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid based on 105 percent of the ASP. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the Ambulatory Payment Class (APC) to which the product is assigned.

- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits are not being updated in 2008.** The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.

- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.

- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the

blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. **For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.**

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.

- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after June 16, 2008, the July 2008 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after June 16, 2008, the July 2008 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

The payment files will be applied to claims processed or reprocessed on or after the implementation date of CR6049 for the dates of service noted in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
July 2008 ASP and ASP NOC files	July 1, 2008 through September 30, 2008
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008
October 2007 ASP and ASP NOC files	October 1, 2007, through December 31, 2007
July 2007 ASP and ASP NOC files	July 1, 2007, through September 30, 2007
April 2007 ASP and ASP NOC files	April 1, 2007, through June 30, 2007
January 2007 ASP and ASP NOC files	January 1, 2007, through March 31, 2007

Note: *The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim makes these determinations.*

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

To see the official instruction (CR6049) issued to your Medicare contractor visit **http://www.cms.hhs.gov/Transmittals/downloads/R1529CP.pdf** on the CMS Web site.

If you have questions, please contact your Medicare contractor at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

July Quarterly Update for 2008 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule (MM6022) (GEN)

MLN Matters Number: MM6022 - Revised
Related CR Release Date: May 23, 2008
Related CR Transmittal #: R1516CP
Related Change Request (CR) #: 6022
Effective Date: January 1, 2008
Implementation Date: July 7, 2008

Note: *This article was revised on June 2, 2008, to reflect an effective date (see above) of January 1, 2008. All other information remains the same.*

Provider Types Affected
Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6022, which provides the quarterly update to the July 2008 DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure your billing staffs are aware of these changes.

Background
This recurring update notification, CR6022, provides specific instructions regarding the July quarterly update for 2008 for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained at 42 CFR 414.102.

The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at **http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf** on the Centers for Medicare & Medicaid Services (CMS) Web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is at **http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp** on the CMS Web site.

Key Points

- The following Healthcare Common Procedure Coding System (HCPCS) codes were added to the HCPCS file effective January 1, 2008 and the fee schedule amounts for these HCPCS codes may be established as part of this update and are effective for claims with dates of service on or after January 1, 2008.

Code	Description	Code	Description
A5083	Continent device, stoma absorptive cover for continent stoma.	E0856	Cervical traction device, cervical collar with inflatable air bladder.
E2227	Manual wheelchair accessory, gear reduction drive wheel, each.	E2228	Manual wheelchair accessory, wheel braking system and lock, complete, each.
E2397	Power wheelchair accessory, lithium-based battery, each.	L3927	Finger orthosis, proximal interphalangeal (pip)/distal interphalangeal (dip),without joint/spring, extension/flexion (e.g. static or ring type), may include soft interface material, prefabricated, includes fitting and adjustment.
L7611	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric.	L7612	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric

Code	Description	Code	Description
L7613	Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric	L7614	Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric
L7621	Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined.	L7622	Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any size, lined or unlined.

- The above codes were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for these codes with dates of service on or after January 1, 2008 that have already been processed will not be adjusted to reflect the newly established fees if they are resubmitted for adjustment.

- The fee schedule amounts for the following codes are being revised as part of this quarterly update to correct fee schedule calculation errors and the revised fee schedule amounts will be added to the fee schedule file as part of this update.

Code	Description	Code	Description
L3905	Wrist hand orthosis, includes one or more nontorsion joints, elastic bands. Turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment.	L3806	Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material straps, custom fabricated, includes fitting and adjustment.
L3808	Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment.		

- Your Medicare contractor will adjust previously processed claims for codes L3905, L3806 and L3808 with dates of service on or after January 1, 2008 if they are resubmitted for adjustments.

- HCPCS code K0672 (Addition to Lower Extremity Orthosis, Removable Soft Interface, All Components, Replacement Only, Each) was added to the HCPCS file effective April 1, 2008.

- The fee schedule amounts for HCPCS code E0461 (Volume Control Ventilator, Without Pressure Support Mode, May Include Pressure Control Mode, Used with Non-Invasive Interface (e.g. Mask)) were inadvertently dropped from the January 2008 DMEPOS fee schedule file and the file was subsequently revised to add the fee schedule amounts for code E0461.

Additional Information
For complete details regarding this CR please see the official instruction (CR6022) issued to your Medicare contractor. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1516CP.pdf** on the CMS Web site.

If you have questions, please contact your Medicare contractor at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

Be sure to visit the "What's New" section of our Web site at
http://www.medicarenhic.com/dme/dme_whats_new.shtml
for the latest information and updates regarding the Medicare program and DME MAC A.

July Quarterly Update to 2008 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement (MM6009) (SPE)

MLN Matters Number: MM6009
Related CR Release Date: May 9, 2008
Related CR Transmittal #: R1501CP
Related Change Request (CR) #: 6009
Effective Date: January 1, 2008
Implementation Date: July 7, 2008

Provider Types Affected
Providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in Skilled Nursing Facilities.

Provider Action Needed
This notification provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS). **CR 6009 adds HCPCS code J9303 (Injection, Panitumumab, 10MG)** to the Major Category III.A. Chemotherapy services FI/A/B MAC **Exclusion List** retroactive to January 1, 2008.

Background
The Social Security Act (Section 1888) codifies the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing (CB). The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services are added by these routine updates; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are not subject to the consolidated billing provision of the SNF PPS. Services not appearing on this list submitted on claims to FIs/A/B MACs and carriers/A/B MACS, including DME MACs, will not be paid by Medicare to providers, other than a SNF, when **included** in SNF Consolidated Billing (CB).

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. Services **excluded** from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems will edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

CR 6009 adds HCPCS code J9303 to the Major Category III.A. Chemotherapy services FI/A/B MAC **Exclusion List retroactive to January 1, 2008.**

Medicare contractors will reopen and reprocess claims affected by this instruction when providers bring such claims to their contractor's attention.

Additional Information
The official instruction, CR 6009, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1501CP.pdf** on the CMS Web site.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

New "K" Code for Replacement Interface Material (MM6075) (O&P)

MLN Matters Number: MM6075
Related CR Release Date: June 13, 2008
Related CR Transmittal #: R1534CP
Related Change Request (CR) #: 6075
Effective Date: April 1, 2008
Implementation Date: June 27, 2008

Provider Types Affected
Providers who bill Medicare fiscal intermediaries and Medicare Administrative Contractors (A/B MAC) for providing lower extremity orthosis services to Medicare beneficiaries.

What You Need to Know
CR 6075, from which this article is taken, announces that (effective April 1, 2008) a new temporary "K" code (K0672 - Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each) has been established for replacement interface material. Make sure that your billing staffs are aware of this new temporary K code.

Additional Information
You can find more the official instruction (CR6075) issued regarding the new "K" code for replacement interface material at **http://www.cms.hhs.gov/Transmittals/downloads/R1534CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) Web site.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

October Quarterly Update to 2008 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement (MM6111) (GEN)

MLN Matters Number: MM6111
Related CR Release Date: June 20, 2008
Related CR Transmittal #: R1537CP
Related Change Request (CR) #: 6111
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6111 which provides the October quarterly update to the 2008 Healthcare Common Procedure Coding System (HCPCS) codes for Skilled Nursing Facility (SNF) consolidated billing (CB) enforcement.

Background
The Social Security Act (Section 1888; see **http://www.ssa.gov/OP_Home/ssact/title18/1888.htm** on the Internet) codifies Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing (CB), and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the CB provision of the SNF PPS. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law.

Services appearing on this list of updated HCPCS codes that are submitted on claims to Medicare Fiscal Intermediaries, Carriers, or A/B MACs will not be paid by Medicare to any providers other than a Skilled Nursing Facility (SNF) **when included** in SNF Consolidated Billing (CB).

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.

Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

For October 1, 2008, the only change is that Medicare systems will add HCPCS code L5670 (ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED SUPRACONDYLAR SUSPENSION ('PTS' OR SIMILAR)) to the File 1 Coding list. Your Medicare contractor will reopen and reprocess claims with dates of service on or after January 1, 2008 that are affected by this change if you bring such claims to their attention.

Additional Information
The official instruction, CR 6111, issued to your carrier or A/B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1537CP.pdf** on the CMS Web site.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

Reporting of Hematocrit or Hemoglobin Levels on All Claims for the Administration of Erythropoiesis Stimulating Agents (ESAs), Implementation of New Modifiers for Non-ESRD ESA Indications, and Reporting of Hematocrit or Hemoglobin Levels on all Non-ESRD, Non-ESA Claims Requesting Payment for Anti-Anemia Drugs (MM5699) (GEN)

MLN Matters Number: MM5699 - Revised
Related CR Release Date: January 11, 2008
Related CR Transmittal #: R1412CP
Related Change Request (CR) #: 5699
Effective Date: January 1, 2008
Implementation Date: April 7, 2008

Note: *This article was revised on May 16, 2008, to delete the words "decimal implied" in the third bullet item on page 3 that discusses reporting of the MEA segment. The values for the most recent numeric test result should be reported with decimals. All other information remains the same.*

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, including durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Competitive Acquisition Plan (CAP) Designated Carriers, and A/B Medicare administrative contractors (A/B MACs)) for providing ESAs and related anti-anemia administration services to Medicare beneficiaries.

Impact on Providers
Effective for services on or after January 1, 2008, you must report the most recent hemoglobin or hematocrit levels on any claim for a Medicare patient receiving: (1) ESA administrations, or (2) Part B anti-anemia drugs other than ESAs used in the treatment of cancer that are not self-administered. In addition, non-ESRD claims for the administration of ESAs must also contain one of three new Healthcare Common Procedure Coding System (HCPCS) modifiers effective January 1, 2008. Failure to report this information will result in your claim being returned as unprocessed. (**Note that renal dialysis facilities are already reporting this information on claim types 72X, so CR5699 applies to providers billing with other types of bills.**) See the rest of this article for reporting details.

Background
Medicare Part B provides payment for certain drugs used to treat anemia caused by the cancer itself or by various anti-cancer treatments, including chemotherapy, radiation, and surgical therapy. The treatment of anemia in cancer patients commonly includes the use of drugs, specifically ESAs such as recombinant erythropoietin and darbepoetin. Emerging data and recent research has raised the possibility that ESAs administered for a number of clinical indications may be associated with significant adverse effects, including a higher risk of mortality in some populations.

Most recently, section 110 of Division B of the Tax Relief and Health Care Act (TRHCA) of 2006 directs the Secretary to amend Section 1842 of the Social Security Act by adding at the end the following new subsection: *"Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual."*

In light of the health and safety factors and the TRHCA legislation, effective January 1, 2008, the Centers for Medicare & Medicaid Services (CMS) is implementing an expanded reporting requirement for all claims billing for administrations of an ESA. Hematocrit and /or hemoglobin readings are already required for ESRD claims for administrations of an ESA. Effective with the implementation of change request (CR) 5699, all other claims for ESA administrations will also require the reporting of the most recent hematocrit or hemoglobin reading, along with one of three new HCPCS modifiers effective January 1, 2008.

In addition, CR 5699 requires the reporting of the most recent hematocrit or hemoglobin readings on all claims for the administration of Part B anti-anemia drugs OTHER THAN ESAs used in the treatment of cancer that are not self-administered.

What you Need to Know
CR 5699, from which this article is taken, instructs all providers and suppliers that:

1. Effective January 1, 2008, all claims billing for the administration of an ESA with HCPCS codes J0881, J0882, J0885, J0886 and Q4081 must report the most recent hematocrit or hemoglobin reading available when the billed ESA dose was administered. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month. Claims submitted prior to the publication of change request 5699 that were not completed per the instructions in change request 5699 should be re-submitted.

- For institutional claims, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49. Such claims for ESAs not reporting a value code 48 or 49 will be returned to the provider.

- Effective for services on or after January 1, 2008, for professional paper claims, test results are reported in item 19 of the Form CMS-1500 claim form. For professional electronic claims (837P) billed to carriers or A/B MACs, providers report the hemoglobin or hematocrit readings in Loop 2400 MEA segment. The specifics are MEA01=TR (for test results), MEA02=R1 (for hemoglobin) or R2 (for hematocrit), and MEA03=the test results. The test results should be entered as follows: TR= test results, R1=hemoglobin or R2=hematocrit (a 2-byte alpha-numeric element), and the most recent numeric test result (a 3-byte numeric element [xx.x]). Results exceeding 3-byte numeric elements (10.50) are reported as 10.5.

  Examples: If the most recent hemoglobin test results are 10.50, providers should enter: TR/R1/10.5, or, if the most recent hematocrit results are 32.3, providers would enter: TR/R2/32.3.

- Effective for dates of service on and after January 1, 2008, contractors will return to provider paper and electronic professional claims, or return as unprocessable paper and electronic institutional claims for ESAs when the most recent hemoglobin or hematocrit test results are not reported.

- When Medicare returns a claim as unprocessable for ESAs with HCPCS codes J0881, J0882, J0885, J0886, or Q4081 for failure to report the most recent hemoglobin or hematocrit test results, it will include Claim Adjustment Reason Code 16 (Claim/service lacks information which is needed for adjudication.) and Remittance Advice Code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with complete/correct information.)

2. Effective January 1, 2008, all non-ESRD ESA claims billing HCPCS J0881 and J0885 must begin reporting one (**and only one**) of the following three modifiers on the same line as the ESA HCPCS:
   - EA: ESA, anemia, chemo-induced;
   - EB: ESA, anemia, radio-induced; or
   - EC: ESA, anemia, non-chemo/radio

- Non-ESRD ESA institutional claims that do not report one of the above three modifiers along with HCPCS J0881 or J0885 will be returned to the provider.

- Non-ESRD ESA professional claims that are billed without one of the three required modifiers as line items along with HCPCS J0881 or J0885 will be returned as unprocessable with reason code 4 and remark code MA130. If more than one modifier is reported, the claim will be returned with reason code 125 and remark code N63.

3. Effective January 1, 2008, all non-ESRD, non-ESA claims billing for the administration of Part B anti-anemia drugs used in the treatment of cancer that are not self-administered must report the most recent hematocrit or hemoglobin reading. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month.

- Institutional claims that do not report the most recent hematocrit or hemoglobin reading will be returned to the provider.

- Professional claims that do not report the most recent hematocrit or hemoglobin reading will be returned as unprocessable using Reason Code 16, and Remarks Codes MA130 and N395

- Your Medicare contractor will not search for claims with dates of service on or after January 1, 2008, processed prior to implementation of this CR, but will adjust such claims when you bring them to the attention of your contractor.

Additional Information
For complete details regarding this CR please see the official instruction (CR5699) issued to your Medicare carrier, FI, DME MAC, CAP Designated Carrier, and A/B MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1412CP.pdf** on the CMS Web site.

If you have questions, please contact your Medicare carrier, FI, DME MAC, CAP Designated Carrier, or A/B MAC at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

Fee Schedule Updates (GEN)

The 2006 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Web site, **http://www.medicarenhic.com/dme/dmfees.shtml**. The following notices have been posted:

- July Updates to 2008 Jurisdiction A DME MAC Fee Schedule
- July 2008 Quarterly Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2008 Oral Anticancer Drug Fees

Note: The January 1 fees for the current calendar year are posted as the "Jurisdiction A DME MAC Fee Schedule" for that particular year, and these files are not changed throughout the year. Rather, separate notices are posted as fee revisions/updates become available. Please be sure you are viewing the appropriate file/notice for the item and date of service.

Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

Delay of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CMS Message 2008-07-16) (GEN)

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Items that had been included in the first round of the DMEPOS Competitive Bidding Program can be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule. Additional guidance regarding this new law will be forthcoming.

Cancellation of Accreditation Deadlines for Second Round of DMEPOS Competitive Bidding (CMS Message 2008-07-21) (GEN)

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. As a result of this delay, the special accreditation deadlines previously established for the second round of the program have been cancelled. Specifically, prior to enactment of this new law, suppliers must have been accredited or have applied for accreditation by July 21, 2008 to be eligible to submit a bid for the second round of competitive bidding and must have obtained accreditation by January 14, 2009 to be eligible for a second round contract. Both of these deadlines have been cancelled and no longer apply.

The deadline of September 30, 2009 that was previously established by which all DMEPOS suppliers must be accredited is still in effect.

For information about the Medicare DMEPOS Competitive Bidding program, visit:
http://www.cms.hhs.gov/DMEPOSCompetitiveBid/

Delay of the National DMEPOS Competitive Bidding Program: Claims Processing (CMS Message 2008-07-21) (GEN)

Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 delays the DMEPOS Competitive Bidding Program. Therefore, in the 10 areas where competitive bidding was initiated, Medicare will pay for DMEPOS items, retroactive to June 30, 2008, using the standard DMEPOS fee schedule amounts. CMS will begin processing all incoming claims under standard FFS rules, no later than July 28, 2008. Any claims that were held will be processed no later than August 4, 2008. To the extent possible, CMS will also automatically reprocess claims that were paid under the Competitive Bidding Program and those claims denied based solely due to DMEPOS Competitive Bidding Program rules.

Note that in some instances suppliers will need to alert the contractor to claims that should be adjusted.

CMS will soon issue contractor instructions and issue accompanying *MLN Matters* articles with more information.

Claim Status Category Code and Claim Status Code Update (MM6090) (GEN)

MLN Matters Number: MM6090
Related CR Release Date: June 13, 2008
Related CR Transmittal #: R1533CP
Related Change Request (CR) #: 6090
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Part A/B Medicare Administrative Contractors (A/B MAC), and Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for services provided to Medicare beneficiaries.

What You Need to Know
CR 6090, from which this article is taken, reminds providers of the periodic updates to the Claim Status Codes and Claim Status Category Codes that Medicare contractors use with the Health Care Claim Status Request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

Background
The Claim Category and Claim Status Codes explain the status of submitted claims. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved codes in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1).

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) to decide about additions, modifications, and retirement of existing codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

CR 6090, from which this article is taken, updates the changes in the Claim Status Codes and Claim Status Category Codes from the February 2008 committee meeting, which were posted at **http://www.wpc-edi.com/content/view/180/223/** on February 29, 2008 (previously referenced by **http://www.wpc-edi.com/codes**). CR6090 reminds Medicare contractors that they must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by its implementation date (October 6, 2008). On and after this date, these code changes are to be used in editing of all X12 276 transactions processed, and to be reflected in the X12 277 transactions issued.

Additional Information
You can find the official instruction, CR6090, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R1533CP.pdf** on the CMS Web site

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

Common Electronic Data Interchange (CEDI) Updates (GEN)

The Common Electronic Data Interchange (CEDI) is a contract that was awarded to National Government Services by CMS to provide a standard front-end system for all DME MAC electronic trading partners/submitters. CEDI provides a single front-end solution for the submission and retrieval of DME MAC electronic transactions.

The following electronic transactions are handled by CEDI:

- Electronic claims (ANSI X12N 837 and NCPDP)
- Delivery of all electronic front end reports
- Delivery of Electronic Remittance Advices (ERA)
- 276/277 Claim Status Request/Response Transactions

CEDI does not handle the enrollment applications or support for Claim Status Inquiry (CSI) or Electronic Funds Transfer (EFT). CSI and EFT is handled by each DME MAC Jurisdiction.

CEDI Resources
The following CEDI resources are available:

Web site - **http://www.ngscedi.com**

Listserv - Available on the CEDI Web site under Listserv Registration

CEDI Help Desk

- 1-866-311-9184
- Hours of operation are 9:00 a.m. - 9:00 p.m. (Eastern Time)
- **E-mail** - **ngs.cedihelpdesk@wellpoint.com**

The CEDI Help Desk will answer questions and provide support for the following:

- Support for the HIPAA compliant Electronic Formats
  - X12N 837 Claims
  - NCPDP Claims
  - X12N 276 Claim Status Request and X12N 277 Claim Status Response
  - X12N 835 Electronic Remittance Advice
- CEDI Password Reset Requests (Call 1-866-311-9184 and select Option 3)
- CEDI Enrollment Status
  - X12N 837 Claims
  - NCPDP Claims
  - X12N 276 Claim Status Request and X12N 277 Claim Status Response
  - X12N 835 Electronic Remittance Advice
- Software Support for
  - Express Plus
  - PCAce Pro32
  - MREP
- Verification of the receipt of electronic files
- Support of VMS Pre-Pass Error Reports
- Testing support for vendors and new electronic trading partners/submitters

Sign up for the CEDI Listserv today!
All entities participating with CEDI, including electronic trading partners, DME MAC suppliers submitting electronic claims, software vendors, billing services and/or clearinghouses should sign up for the CEDI listserv.

The CEDI listserv will keep you informed of all CEDI updates and changes. Currently many of the CEDI listservs are submitted through the listservs provided by the DME MAC Jurisdictions. Eventually CEDI listserv will only be sent through the CEDI listserv, so sign up today.

To sign up for the CEDI listserv, click on the following link:
http://www.ngscedi.com/listserv/subscribe.htm

Frequently Asked Questions document is available on the CEDI Web site
National Government Services, Common Electronic Data Interchange (CEDI) has a Frequently Asked Questions (FAQ) document on the CEDI Web site.

The FAQ document is a great resource to use prior to contacting the CEDI Help Desk. To locate the FAQ document, go to the "Resource Materials" section using the following link:
http://www.ngscedi.com/outreach_materials/outreachindex.htm

Electronic Front End Reports delivered by CEDI
It is essential that all Trading Partners/Electronic Submitter download and review all front end reports returned by CEDI.

National Government Services, Common Electronic Data Interchange (CEDI) creates and delivers the following Level I reports for each claim file submitted:

- TA1 (**Note:** *Some systems may generate a TA1 report for accepted and rejected files, others will only generate a TA1 if the file rejects. Check with your software vendor to determine if your system generated both an accepted and/or rejected TA1.*)
- TRN
- 997
- GenResponse (GENRPT)

For more information on the Level I reports, access the CEDI Front End Reports Reference Document under the Resource Materials section of the CEDI Web site at:
http://www.ngscedi.com/outreach_materials/outreachindex.htm

Questions regarding rejections on the TA1, TRN and/or 997 should be directed to your software vendor. Your vendor will know what needs to be corrected in order to pass these edits.

CEDI will provide support for the GenResponse (GENRPT) report.

Electronic trading partners/submitters will also receive a Level II report from each DME MAC Jurisdiction that received claims in the file(s) sent to CEDI. These Level II reports are created by the DME MACs and delivered by CEDI.

Electronic Trading Partners/Submitters should first review the *DME MAC Front End Edit Error Code Manual* to identify the cause of the error before contacting the CEDI Help Desk. For more information on the DME MAC Level II errors, descriptions and report examples, access the *DME MAC Front End Edit Error Code Manual* under the Resource Materials section of the CEDI Web site at:
http://www.ngscedi.com/outreach_materials/outreachindex.htm

Note: Common Front End Edits (i.e. 20004, 20011, 20322, 40014 and many more) are listed in the *DME MAC Front End Edit Error Code Manual*. This manual provides the edit number/code, edit descriptions and edit explanations. Examples of these reports are included in the back of the manual.

Commonly asked questions on the Electronic Front End Reports are located in the CEDI Frequently Asked Questions (FAQ) Document and can be accessed using the following link:
http://www.ngscedi.com/outreach_materials/outreachindex.htm

CEDI created the resources referenced above to assist DME MAC electronic trading partners with understanding the electronic reports delivered by CEDI.

B108 Warning Message on the CEDI GenResponse (GENRPT) Report
Attention: All CEDI Trading Partners/Electronic Submitters, Software Vendors, Billing Services and Clearinghouses

The Common Electronic Data Interchange (CEDI) provides a B108 error message on the CEDI GenResponse (GENRPT) Report when the NPI is not linked to the Trading Partner (Submitter) ID. At this time, this is a warning message and does not reject claims submitted. Accepted claims with the B108 warning message are being forwarded to the appropriate DME MAC where front end edits will continue to be performed. These edits will validate the supplier is authorized for EDI transactions and perform NPI validation.

The CEDI edit B108 will be changed from a warning to a rejection on or before September 30, 2008. At that time claims that do not have an NPI matched to the Trading Partner (Submitter) ID will be rejected by CEDI and will not be forwarded to the DME MACs. It is important that electronic trading partners complete the steps below to correct the B108 warning message now and avoid future rejection of claims.

All DME MAC Electronic Trading Partners that receive the B108 warning message should complete the following steps. (If a Supplier Authorization Form has previously been submitted to CEDI for the Submitter ID and supplier NPI receiving the B108 warning message, please do not complete the steps below.)

1. The supplier must complete the Supplier Authorization Form by clicking on the following link: **http://www.ngscedi.com/forms/formsindex.htm**
2. Once complete, click on the submit button at the bottom of the form
3. Print the form
4. Sign the form on the last page where it indicates "Authorized DME Supplier Signature"
5. List the title of the signer and the date signed
6. Fax the form to CEDI at 315-442-4299
7. Retain a copy for your records

Note: The Supplier Authorization Form cannot be signed by a third party. This form MUST be signed by the supplier.

The CEDI Enrollment Team is processing all enrollment requests in the order they are received and will respond once your setup is complete.

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Updates (CR6109) (GEN)

Effective October 01, 2008 Change Request (CR) 6109 announces the release of the Remittance Advice and Claim Adjustment Reason Code updates. The complete list of reason codes is available from Washington Publishing, visit their Web site at:
http://www.wpc-edi.com/codes

For information on the new codes, modified codes, and deactivated codes that are involved in this update, you can review CR 6109 at:
http://www.cms.hhs.gov/transmittals/downloads/R1563CP.pdf

If you have any further questions regarding the reason code updates you can contact customer service at:
866-590-6731

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (MM6109) (GEN)

MLN Matters Number: MM6109
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R1563CP
Related Change Request (CR) #: 6109
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected
Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Impact on Providers
CR 6109, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARC) used in electronic and paper remittance advice, and Claim Adjustment Reason Codes (CARC) used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective October 1, 2008.

Be sure that your billing staffs are aware of these changes.

Background
Two code sets - the reason and remark code sets - must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-of-benefits (COB) transactions.

The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year and are posted on the Washington Publishing Company (WPC) Web site at **http://www.wpc-edi.com/Codes** on the Internet. The tables at the end of this article (right after the "*Additional Information*" section) summarize the latest changes to these lists, as announced in CR6109.

CMS has also developed a tool to help you search for a specific category of RARC code and that tool is available at **http://www.cmsremarkcodes.info** on the Internet. Note that this Web site does not replace the WPC site and, should there be any discrepancies in what is posted at this site and the WPC site, consider the WPC site to be correct.

Additional Information
To see the official instruction (CR 6109) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to **http://www.cms.hhs.gov/Transmittals/downloads/R1563CP.pdf** on the CMS Web site.

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* at **http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf** on the CMS Web site.

If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

The changes that are effective on October 1, 2008 are as follows:

Remittance Advice Remark Code changes

New Codes

Code	Current Narrative	Medicare Initiated
N433	Resubmit this claim using only your National Provider Identifier (NPI)	Y

Modified Codes

Code	Current Modified Narrative	Last Modified
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.	2/29/2008
N175	Missing review organization approval.	2/29/2008
N241	Incomplete/invalid review organization approval.	2/29/2008
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.	2/29/2008

Deactivated Codes

Code	Current Narrative	Last Modified
None		

Health Care Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Effective Date (per WPC Web site)
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	1/27/2008
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)	1/27/2008
215	Based on subrogation of a third party settlement	1/27/2008
216	Based on the findings of a review organization	1/27/2008
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)	1/27/2008
218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only)	1/27/2008
219	Based on extent of injury (Note: To be used for Workers' Compensation only)	1/27/2008
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only)	1/27/2008
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution)	1/27/2008
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/27/2008

Modified Codes

Code	Modified Narrative	Effective Date (per WPC Web site.
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	1/27/2008

Deactivated Codes

Code	Current Narrative	Effective Date (per WPC Web site)
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/1/2009

Sign up for the CEDI Listserv today (GEN)

All entities participating with CEDI, including electronic trading partners, DME MAC suppliers submitting electronic claims, software vendors, billing services and/or clearinghouses should sign up for the CEDI listserv.

The CEDI listserv will keep you informed of all CEDI updates and changes. Currently many of the CEDI listserves are submitted through the listserves provided by the DME MAC Jurisdictions. Eventually CEDI listserv will only be sent through the CEDI listserv, so sign up today.

To sign up for the CEDI listserv, click on the following link:
http://www.ngscedi.com/listserv/subscribe.htm

VMS Modifications to Implement the Common Electronic Data Interchange (CEDI) System - Part II (MM6026) (GEN)

MLN Matters Number: MM6026
Related CR Release Date: May 23, 2008
Related CR Transmittal #: R344OTN
Related Change Request (CR) #: 6026
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected
Suppliers submitting claims to Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6026 which provides VMS modification details needed to implement the Common Electronic Data Interchange (CEDI) system. The article is informational purposes for suppliers. Suppliers should note that the claims control number (CCN) format for X12 (837) claims will be CYYJJJBBBBSS000, where C=Century, YY = Year, JJJ = Julian Day, BBBB = Batch Number, SS = Sequence Number, and 000 is a number for internal CMS system use only. This format will be in the system changes implemented on October 6, 2008 as a result of CR6026.

Background
Currently, front end electronic data interchange (EDI) processing for Durable Medical Equipment (DME) claims occurs in four separate systems. Two of these systems are operated by DME MACs, and two are operated by data services contractors under direct contract with the Centers for Medicare & Medicaid Services (CMS). These front-end EDI systems perform edits on incoming Medicare DME claims and forward the output data from transactions that pass edits to the core of the VMS shared system claims processing environment. Each of the four systems used for DME front end transaction processing has been developed as a proprietary system to meet its developer's own business objectives, and logic specific to Medicare requirements was added to accommodate the Medicare claims transactions.

Since each system is owned and developed by separate entities, variations exist in the way in which individual front end systems process claims and in the results they produce. This creates confusion with suppliers and beneficiaries, and can also lead to the rejection of eligible claims as well as the payment of ineligible claims depending upon which front end system processed the transaction.

CR 6026 provides business requirements regarding system changes necessary to prepare for the implementation of the DME MAC CEDI front end system. The business requirements associated with CR 6026 are effective on October 1, 2008 regardless of the date of service or date of receipt of the claim.

Note: *CR 6026 does not affect providers billing carriers, Fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), or Part A/B MACs.*

Additional Information
The official instruction, CR 6026, issued to your DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R344OTN.pdf** on the CMS Web site.

If you have any questions, please contact your DME MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

Additional Information on Reporting a National Provider Identifier (NPI) for Ordering / Referring and Attending / Operating / Other / Service facility for Medicare Claims (MM5890) (GEN)

MLN Matters Number: MM5890 - Revised
Related CR Release Date: January 18, 2008
Related CR Transmittal #: R235PI
Related Change Request (CR) #: 5890
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Note: *This article was rescinded on May 30, 2008.*

Effective August 18, 2008 - SADMERC Transition to NAS PDAC (GEN)

Noridian Administrative Services, LLC (NAS) has been named the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare & Medicaid Services. By August 18, 2008, NAS will perform the following activities that Palmetto GBA, as the Statistical Analysis DME Regional Carrier (SADMERC), currently performs:

- Provide data analysis support to the DME Program Safeguard Contractors (PSCs)
- Guide manufacturers and suppliers on the proper use of the Healthcare Common Procedure Coding
- System (HCPCS) for Medicare billing purposes through product reviews and decisions, the DME
- Coding System (DMECS), and the HCPCS Helpline
- Conduct national pricing functions for DMEPOS services
- Assist CMS with DMEPOS fee schedules

Until the PDAC Web site, **http://www.dmepdac.com**, is launched, please continue to reference the SADMERC Web site, **http://www.palmettogba.com/sadmerc**, for transition updates and information.

Implementation of New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries (MM6139) (GEN)

MLN Matters Number: MM6139 - Revised
Related CR Release Date: August 8, 2008
Related CR Transmittal #: R22COM
Related Change Request (CR) #: 6139
Effective Date: March 1, 2009
Implementation Date: January 5, 2009

Note: *This article was revised on August 13, 2008, to change the title to more accurately reflect the Change Request requirements. Additionally, changes were made to further clarify the authentication requirements. In particular, the note on page 2 was changed to show that you will only be allowed three attempts to correctly provide your NPI, PTAN, AND last 5-digits of your TIN.*

Provider Types Affected
CR 6139 impacts all physicians, providers, and suppliers (or their staffs) who make inquiries to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)). Inquiries include written inquiries or calls made to Medicare contractor provider contact centers, including calls to Interactive Voice Response (IVR) systems.

What You Need to Know
CR 6139, from which this article is taken, addresses the necessary provider authentication requirements to complete IVR transactions and calls with a Customer Service Representative (CSR).

Effective March 1, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication: 1) Your National Provider Identifier (NPI); 2) Your Provider Transaction Access Number (PTAN); and 3) The last 5-digits of your tax identification number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Background
In order to comply with the requirements of the Privacy Act of 1974 and of the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee-for-service provider contact centers must properly authenticate callers and writers before disclosing protected health information.

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last 5-digits of the provider's TIN as an additional element in the provider authentication process. Your Medicare contractor's system will verify that the NPI, PTAN, and last 5-digits of the TIN are correct and belong to you before providing the information you request.

Note: *You will only be allowed three attempts to correctly provide your NPI, PTAN, and last 5-digits of your TIN.*

As a result of CR 6139, the Disclosure Desk Reference for Provider Contact Centers, which contains the information Medicare contractors use to authenticate the identity of callers and writers, is updated in the *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information) and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information) to reflect these changes.

New information in these manual chapters also addresses other authentication issues. This new information is summarized as follows:

Authentication of Providers with No NPI
Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information.

Since these types of inquiries are likely to result in additional CSR inquiries, before releasing information to the provider, CSRs will authenticate using at least two other data elements available in the provider's record, such as provider name, TIN, remittance address, and provider master address.

Beneficiary Authentication
Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication: 1) last name, 2) first name or initial, Health Insurance Claim Number (HICN), 3) and either date of birth (eligibility, next eligible date), and 4) Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim) or date of service (claim status, CMN/DIF (post-claim.)).

Written Inquiries
In general, three data elements (NPI, PTAN, and last 5-digits of the TIN) are required for authenticating providers' written inquiries. This includes inquiries received without letterhead (including hardcopy, fax, email, pre-formatted inquiry forms or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs)).

The exception to this requirement is written inquiries received on the provider's official letterhead (including emails with an attachment on letterhead). In this case, provider authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the provider's practice location and name on the letterhead must match the contractor's file for this provider. (However, your Medicare contractor may use discretion if the file does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match either, the NPI, PTAN, or last 5-digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last 5-digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

Overlapping Claims
When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that provider by verifying his/her name, NPI, PTAN, last 5-digits of the TIN, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information.

Additional Information
You can find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located at **http://www.cms.hhs.gov/Transmittals/downloads/R22COM.pdf** on the CMS Web site.

If you have any questions, please contact your Medicare contractor (carrier, FI, RHHI, A/B/MAC, or DME MAC) at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

Important Information on the New Medicare Law - The Medicare Improvements for Patients and Providers Act of 2008 (SE0826) (GEN)

MLN Matters Number: SE0826
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

This article contains a compilation of messages that were issued on July 16, 2008.

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. This legislation alters a number of Medicare policies, which have been the subject of a number of change requests (CRs) and MLN Matters articles published in recent months. The Centers for Medicare & Medicaid Services (CMS) is in the process of revising these previously issued CRs and MLN Matters articles as a result of this legislation. However, CMS feels it is important that physicians, providers and suppliers be aware of five critical issues immediately.

These five issues are:

- New 2008 Medicare Physician Fee Schedule (MPFS) payment rates effective for dates of service July 1, 2008 through December 31, 2008;
- Extension of the exceptions process for the therapy caps;
- A delay in the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program;
- Reinstatement of the moratorium that allows independent laboratories to bill for the technical component (TC) of physician pathology services furnished to hospital patients; and
- Extension of the payment rule for Brachytherapy and Therapeutic Radiopharmaceuticals.

Be sure your billing staff is aware of these changes.

Background
The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. While MIPPA calls for numerous changes to the Medicare program, this special edition article covers five key provisions as noted above.

1. New 2008 Medicare Physician Fee Schedule (MPFS) Payment Rates Effective for Dates of Service July 1, 2008 through December 31, 2008
As a result of this legislation, the mid-year 2008 MPFS rate of -10.6 percent has been replaced with the January-June 2008 0.5 percent update, retroactive to July 1, 2008.

Physicians, non-physician practitioners and other providers of services paid under the MPFS should begin to receive payment at the 0.5 % update rates in approximately 10 business days, or less, for claims with dates of service on or after July 1, 2008. Medicare contractors are currently working to update their payment system with the new rates.

In the meantime, to avoid a disruption to the payment of claims for physicians, non-physician practitioners and other providers of services paid under the MPFS, Medicare contractors will continue to process the claims with dates of service on or after July 1, 2008, that have been on hold. These claims will be processed on a rolling basis (first in/first out) for payment at the -10.6% update level. After your Medicare contractor begins to pay claims at the new 0.5% rate, to the extent possible, the contractor will begin to automatically reprocess any claims paid at the lower rates.

Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the January 1 - June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount will require providers to contact their local contractor for direction on obtaining adjustments. Non-participating physicians who submitted unassigned claims at the reduced nonparticipation amount also will need to request an adjustment.

Medicare contractor web sites are being updated with the new rates and these should be available shortly. Be aware that any published MLN Matters articles affected by the new law will be revised or rescinded as appropriate.

2. Extension of Therapy Cap Exceptions
Another key provision of the MIPPA legislation extends the effective date of the exceptions process to the therapy caps to December 31, 2009. Outpatient therapy service providers may now resume submitting claims with the KX modifier for therapy services that exceed the cap furnished on or after July 1, 2008.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1810 for calendar year 2008. For occupational therapy services, the limit is $1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and report the KX modifier will be paid beyond this limit.

Before this legislation was enacted, outpatient therapy service providers were previously instructed to not submit the KX modifier on claims for services furnished on or after July 1, 2008. The extension of the therapy cap exceptions is retroactive to July 1, 2008. As a result, providers may have already submitted some claims without the KX modifier that would qualify for an exception.

Providers submitting these claims using the 837 institutional electronic claim format or the UB-04 paper claim format would have had these claims rejected for exceeding the cap. These providers should resubmit these claims appending the KX modifier so they may now be processed and paid. Providers submitting these claims using the 837 professional electronic claim format or the CMS-1500 paper claim format would have had these claims denied for exceeding the cap. These providers should request to have their claims adjusted in order to have the contractor pay the claim.

In all cases, if the beneficiary was notified of their liability and the beneficiary made payment for services that now qualify for exceptions, any such payments should be refunded to the beneficiary.

3. Delay in the DMEPOS Competitive Bidding Program
This new law also has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Items that had been included in the first round of the DMEPOS Competitive Bidding Program can be furnished by

any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule. Additional guidance regarding the new law's impact on this program will be forthcoming.

4. Reinstatement of the Moratorium That Allows Independent Laboratories to Bill for the TC of Physician Pathology Services Furnished to Hospital Patients

In the final physician fee schedule regulation published in the Federal Register on November 2, 1999, CMS stated that it would implement a policy to pay only the hospital for the technical component (TC) of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory could bill the carrier under the MPFS for the TC of physician pathology services for hospital patients. At the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed. Subsequent legislation formalized a moratorium on the implementation of the rule. As such, during this time, Medicare contractors have continued to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.

The most recent extension of the moratorium, established by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), Section 104, expired on June 30, 2008. A new extension of the moratorium has been established by Section 136 of MIPPA, retroactive to July 1, 2008.

A previous communication (MLN Matters article MM6088) indicated that the moratorium had ended and that independent laboratories may no longer bill Medicare for the TC of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This prohibition is rescinded and the moratorium will continue effective for claims with dates of service on and after July 1, 2008, but prior to January 1, 2010.

5. Extension of Payment Rule for Brachytherapy and Therapeutic Radiopharmaceuticals

MIPPA extends the use of the cost to charge payment methodology for Brachytherapy and Therapeutic Radiopharmaceuticals through January 1, 2010. This change is retroactive to July 1, 2008. Some claims have already been processed, however, using the Outpatient Prospective Payment System (OPPS) rates that were in effect until MIPAA enactment. To avoid a disruption in payment while the cost to charge payment methodology is re-implemented, impacted claims will continue to be paid based on the OPPS rates. Contractors will mass adjust all impacted OPPS claims with dates of service beginning July 1, 2008, as soon as the cost to charge payment methodology has been implemented. Reprocessing of affected claims will be complete by September 30, 2008.

Additional Information

Be on the alert for more information about other legislative provisions which may affect you.

If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (MM6107) (GEN)

MLN Matters Number: MM6107
Related CR Release Date: July 29, 2008
Related CR Transmittal #: R1566CP

Related Change Request (CR) #: 6107
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DMACs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs)).

Impact on Providers

This article is based on Change Request (CR) 6107 and reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2008 (for institutional providers, effective for discharges on or after

October 1, 2008). You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) Web site at **http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp**, or at the National Center for Health Statistics (NCHS) Web site at **http://www.cdc.gov/nchs/icd9.htm** in June of each year.

Background
The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 6107 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs)), and for all institutional claims; but is not required for ambulance supplier claims.

Additional Information
The official instruction (CR 6107) issued to your Medicare contractor is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1566CP.pdf** on the CMS Web site.

As mentioned, you can find the new, revised, and discontinued ICD-9-CM diagnosis codes at **http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp** on the CMS Web site or at the National Center for Health Statistics (NCHS) Web site at **http://www.cdc.gov/nchs/icd9.htm** , in June of each year. The annual ICD-9-CM code changes are also included in a CD-ROM, which you can purchase for $25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided at **http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp** on the CMS Web site.

If you have questions, please contact your Medicare contractor at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

Provider Authentication by Medicare Provider Contact Centers (SE0814) (GEN)

MLN Matters Number: SE0814
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: 5089, 5277
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians, other providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors, (DME MAC)) for services provided to Medicare Beneficiaries.

What You Need to Know
SE0814 covers the implementation of the National Provider Identifier (NPI) and the Provider Transaction Access Number (PTAN), effective May 23, 2008, as the provider authentication elements used when providers make telephone or written inquiries to the Medicare fee-for-service contractor provider contact centers.

Note: *For providers enrolled in Medicare before May 23, 2008, their PTAN initially will be their legacy provider number. New providers enrolling in Medicare on or after May 23, 2008, will be assigned a PTAN as part of the Medicare enrollment process.*

Background
In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare provider contact centers (PCC) must properly authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

Please refer to the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9), chapter 3, section 30 and chapter 6, section 80 for a complete discussion of this PCC authentication update. You can find these manual sections at **http://www.cms.hhs.gov/manuals/downloads/com109c03.pdf** and **http://www.cms.hhs.gov/manuals/downloads/com109c06.pdf** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Provider Authentication
The elements for provider authentication of telephone (either Customer Service Representative (CSR) or Interactive Voice Response (IVR)) and written inquiries are presented in the table below.

Provider Authentication Elements for Telephone & Written Inquiries

EFFECTIVE DATES	INQUIRY TYPE	PROVIDER ELEMENTS TO BE AUTHENTICATED (all elements must match unless otherwise specified)
On or after May 23, 2008	IVR	Provider NPI and PTAN
On or after May 23, 2008	CSR	Provider NPI and PTAN
On or after May 23, 2008	Written, including fax and email	Provider name, and either provider NPI or PTAN

Written Inquiries - Exception to above authentication requirements
CMS allows an exception for written or faxed inquiries submitted on a provider's official letterhead, and e-mail inquiries (with an attachment on letterhead). If the provider's name and address are included in the letterhead and clearly establish the provider's identity, no NPI or PTAN is required for authentication.

Additional Information
If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

Reminders from the Redetermination Department (GEN)

- The Redetermination Department has consistently seen numerous appeals that could have been allowed at the initial claim level had the revised CMN/DIF been submitted with the original claim. In order to reduce your appeals, submit all necessary revision or recertification CMN/DIFs with your electronic claim.
- For claims with ANSI code 175 which states "Prescription is incomplete", send in a valid CMN/DIF (original, recertification, and/or revision) with your resubmission, reopening, or appeal.
- Read the educational articles "*Repairs and Replacement for Beneficiary Owned Equipment*" (**http://www.medicarenhic.com/dme/articles/050908_repairs.pdf**) and "*Electronic Submission of Claims Involving a Break in Service*" (**http://www.medicarenhic.com/dme/articles/091906_bis.pdf**). Following the instructions in these articles will reduce your appeals workload.
- When faxing your appeal requests, check your fax machine to determine if the completed faxes were received. We have had several cases where the Redetermination Department has received incomplete faxes. Incomplete fax transmissions may result in unnecessary dismissals.

Screening DNA Stool Test for Colorectal Cancer (CR 6145) (Transmittal 89) (SPE)

CMS Manual System
Change Request 6145
Date: August 8, 2008

Pub 100-03 Medicare National Coverage Determinations
Transmittal 92

Note: *Transmittal 89, dated July 25, 2008, is rescinded and replaced by Transmittal 92, dated August 8, 2008. The Implementation Date on the Business Requirements was erroneously stated as August 25, 2005. The correct Implementation Date is August 25, 2008. All other material remains the same.*

SUBJECT: Screening DNA Stool Test for Colorectal Cancer

I. SUMMARY OF CHANGES: Following reconsideration of the current national coverage determination (NCD) for colorectal cancer screening, CMS proposes not to expand the colorectal cancer screening benefit to include coverage of PreGen-Plus, a commercially available screening DNA stool test. The FDA determines that this test requires premarket review and approval. A subsequent request for reconsideration will be considered once FDA approval is obtained.

This revision of Pub.100-03, section 210.3 is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare Advantage Organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

New / Revised Material
Effective Date: April 28, 2008
Implementation Date: August 25, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/210.3/Colorectal Cancer Screening Tests

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-03	Transmittal: 92	Date: August 8, 2008	Change Request: 6145

SUBJECT: Screening DNA Stool Test for Colorectal Cancer
Effective Date: April 28, 2008
Implementation Date: August 25, 2005

I. GENERAL INFORMATION

A. Background: Congress has specifically authorized coverage of certain screening tests under Part B of the Medicare program and has made necessary conforming changes in order to ensure that payments are made. As a result, the Centers for Medicare & Medicaid Services (CMS) currently covers colorectal cancer screening for average-risk individuals ages 50 years and older using fecal occult blood testing, sigmoidoscopy, colonoscopy, and barium enema. Neither the law nor regulations identify screening DNA stool tests as a possible coverage option under the colorectal cancer screening benefit. However, under 42 CFR 410.37(a)(1)(v), and section 1861(pp)(1)(D) of the Social Security Act, CMS is allowed to use the national coverage determination (NCD) process to determine coverage of other types of colorectal cancer screening tests not specifically identified in the law or regulations as it determines to be appropriate, and in consultation with appropriate organizations.

B. Policy: Following an external request for reconsideration of the current NCD at Pub. 100-03, National Coverage Determinations Manual, section 210.3, CMS proposes not to expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test, as an alternative to a screening colonoscopy or a screening flexible sigmoidoscopy. The Food and Drug Administration (FDA) determines that this test is a medical device that requires pre-market review and approval prior to marketing, which, to date, has not been obtained. In the absence of an FDA determination, CMS believes that there may be unresolved questions regarding the safety and effectiveness of the stool DNA test, and therefore does not believe that identification of stool DNA mutations is an appropriate colorectal cancer screening test at this time. A subsequent request for reconsideration will be considered once FDA approval is obtained.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6145.1	Contractors shall be aware that effective with a CMS final determination effective April 28, 2008, the NCD for Colorectal Cancer Screening Tests at Pub. 100-03, National Coverage Determinations Manual, section 210.3, remains unchanged. In addition, all current claims processing and billing requirements remain in effect (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280 and Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 60).	X	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6145.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Bill Larson, coverage, 410-786-4639, **William.larson@cms.hhs.gov**,
Pat Brocato-Simons, coverage, 410-786-0261, **patricia.brocatosimons@cms.hhs.gov**
Post-Implementation Contact(s): Appropriate CMS RO

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*:
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

210.3 - Colorectal Cancer Screening Tests
(Rev. 89; Issued: 07-25-08; Effective Date: 04-28-08; Implementation Date: 08-25-08)

A. General

Section 4104 of the Balanced Budget Act of 1997 provides for coverage of screening colorectal cancer procedures under Medicare Part B. Medicare currently covers: (1) annual fecal occult blood tests (FOBTs); (2) flexible sigmoidoscopy over 4 years; (3) screening colonoscopy for persons at average risk for colorectal cancer every 10 years, or for persons at high risk for colorectal cancer every 2 years; (4) barium enema every 4 years as an alternative to flexible sigmoidoscopy, or every 2 years as an alternative to colonoscopy for persons at high risk for colorectal cancer; and, (5) other procedures the Secretary finds appropriate based on consultation with appropriate experts and organizations.

Coverage of the above screening examinations was implemented in regulations through a final rule that was published on October 31, 1997 (62 FR 59079), and was effective January 1, 1998. At that time, based on consultation with appropriate experts and organizations, the definition of the term "FOBT" was defined in 42 CFR §410.37(a)(2) of the regulation to mean a "guaiac-based test for peroxidase activity, testing two samples from each of three consecutive stools."

In the 2003 Physician Fee Schedule Final Rule (67 FR 79966) effective March 1, 2003, *the Centers for Medicare & Medicaid Services (*CMS*)* amended the FOBT screening test regulation definition at 42 CFR §410.37(a)(2) to provide that it could include either: (1) a guaiac-based FOBT, or, (2) other tests determined by the Secretary through a national coverage determination.

***B. Nationally* Covered Indications**
Fecal Occult Blood Tests (FOBT) (effective for services performed on or after January 1, 2004)

1. History
The FOBTs are generally divided into two types: immunoassay and guaiac types. Immunoassay (or immunochemical) fecal occult blood tests (iFOBT) use "antibodies directed against human globin epitopes. While most iFOBTs use spatulas to collect stool samples, some use a brush to collect toilet water surrounding the stool. Most iFOBTs require laboratory processing.

Guaiac fecal occult blood tests (gFOBT) use a peroxidase reaction to indicate presence of the heme portion of hemoglobin. Guaiac turns blue after oxidation by oxidants or peroxidases in the presence of an oxygen donor such as hydrogen peroxide. Most FOBTs use sticks to collect stool samples and may be developed in a physician's office or a laboratory. In 1998, Medicare began reimbursement for guaiac FOBTs, but not immunoassay type tests for colorectal cancer screening. Since the fundamental process is similar for other iFOBTs, CMS evaluated colorectal cancer screening using immunoassay FOBTs in general.

2. Expanded Coverage
Medicare covers one screening FOBT per annum for the early detection of colorectal cancer. This means that Medicare will cover one guaiac-based (gFOBT) or one immunoassay-based (iFOBT) at a frequency of every 12 months; i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed, for beneficiaries aged 50 years and older. The beneficiary completes the existing gFOBT by taking samples from two different sites of three consecutive stools; the beneficiary completes the iFOBT by taking the appropriate number of stool samples according to the specific manufacturer's instructions. This screening requires a written order from the beneficiary's attending physician. ("Attending physician means a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Social Security Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.)

***C. Nationally* Non-*C*overed Indications**
All other indications for colorectal cancer screening not otherwise specified above remain non-covered.

D. Other
N/A
(This NCD last reviewed April 2008.)

Please be sure that you have the most updated version of the IVR Guide and IVR Call Flow in your office, both can be found at: **http://www.medicarenhic.com/dme/contacts.shtml**

Screening DNA Stool Test for Colorectal Cancer (CR 6145) (Transmittal 93) (SPE)

CMS Manual System
Change Request 6145
Date: July 25, 2008

Pub 100-02 Medicare Benefit Policy
Transmittal 93

SUBJECT: Screening DNA Stool Test for Colorectal Cancer

I. SUMMARY OF CHANGES: Following reconsideration of the current national coverage determination (NCD) for colorectal cancer screening, CMS proposes not to expand the colorectal cancer screening benefit to include coverage of PreGen-Plus, a commercially available screening DNA stool test. The FDA determines that this test requires premarket review and approval. A subsequent request for reconsideration will be considered once FDA approval is obtained.

New / Revised Material
Effective Date: April 28, 2008
Implementation Date: August 25, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/280/Preventive and Screening Services

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
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SECTION B: For Medicare Administrative Contractors (MACs): The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-02	Transmittal: 93	Date: July 25, 2008	Change Request: 6145

SUBJECT: Screening DNA Stool Test for Colorectal Cancer

Effective Date: April 28, 2008

Implementation Date: August 25, 2008

I. GENERAL INFORMATION

A. Background: Congress has specifically authorized coverage of certain screening tests under Part B of the Medicare program and has made necessary conforming changes in order to ensure that payments are made. As a result, the Centers for Medicare & Medicaid

Services (CMS) currently covers colorectal cancer screening for average-risk individuals ages 50 years and older using fecal occult blood testing, sigmoidoscopy, colonoscopy, and barium enema. Neither the law nor regulations identify screening DNA stool tests as a possible coverage option under the colorectal cancer screening benefit. However, under 42 CFR 410.37(a)(1)(v), and section 1861(pp)(1)(D) of the Social Security Act, CMS is allowed to use the national coverage determination (NCD) process to determine coverage of other types of colorectal cancer screening tests not specifically identified in the law or regulations as it determines to be appropriate, and in consultation with appropriate organizations.

B. Policy: Following an external request for reconsideration of the current NCD at Pub. 100-03, National Coverage Determinations Manual, section 210.3, for colorectal cancer screening, CMS proposes not to expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test, as an alternative to a screening colonoscopy or a screening flexible sigmoidoscopy. The Food and Drug Administration (FDA) determines that this test is a medical device that requires pre-market review and approval prior to marketing, which, to date, has not been obtained. In the absence of an FDA determination, CMS believes that there may be unresolved questions regarding the safety and effectiveness of the stool DNA test, and therefore does not believe that identification of stool DNA mutations is an appropriate colorectal cancer screening test at this time. A subsequent request for reconsideration will be considered once FDA approval is obtained.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6145.1	Contractors shall be aware that effective with a CMS final determination effective April 28, 2008, the NCD for Colorectal Cancer Screening Tests at Pub. 100-03, National Coverage Determinations Manual, section 210.3, remains unchanged. In addition, all current claims processing and billing requirements remain in effect (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280 and Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 60).	X	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
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IV. SUPPORTING INFORMATION
Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
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X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS
Pre-Implementation Contact(s): Bill Larson, coverage, 410-786-4639, **William.larson@cms.hhs.gov**, Pat Brocato-Simons, coverage, 410-786-0261, **patricia.brocatosimons@cms.hhs.gov**
Post-Implementation Contact(s): Appropriate CMS RO

VI. FUNDING
Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)*:
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280 - Preventive and Screening Services
(Rev. 93; Issued: 07-25-08; Effective Date: 04-28-08; Implementation Date: 08-2508)

See section 50.4.4.2 for coverage requirements for PPV, hepatitis B vaccine, and Influenza Virus Vaccine.

See *Pub. 100-04*, Medicare Claims Processing Manual, Chapter 18, "Preventive and Screening Services," for coverage requirements for the following:

- §40 for screening pelvic examinations,
- §50 for prostate cancer screening test and procedures,
- *§60 for colorectal cancer screening, and,*
- §70.4 for glaucoma screening.

Screening DNA Stool Test for Colorectal Cancer (MM6145) (GEN)

MLN Matters Number: MM6145 - Revised
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R93BP and R92NCD
Related Change Request (CR) #: 6145
Effective Date: April 28, 2008
Implementation Date: August 25, 2008

Note: *This article was revised on August 11, 2008, to reflect changes made to CR6145. The transmittal number, release date, and Web address for accessing the NCD portion of CR6145 were revised. All other information remains the same.*

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 6145 which announces the Centers for Medicare & Medicaid Services (CMS) decision regarding a request for reconsideration of the current national coverage determination (NCD) for colorectal cancer screening.

What You Need to Know

CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test; because the Food and Drug Administration (FDA) determines that this test requires pre-market review and approval. A subsequent request for reconsideration will be considered once FDA approval is obtained.

What You Need to Do

See the *Background* and *Additional Information* Sections of this article for further details regarding these changes.

Background

Congress specifically authorized coverage of certain screening tests under Part B of the Medicare program and made necessary conforming changes in order to ensure that payments are made. As a result, CMS currently covers colorectal cancer screening for average-risk individuals ages 50 years and older using fecal occult blood testing, sigmoidoscopy, colonoscopy, and barium enema.

Neither the law nor regulations identify screening DNA stool tests as a possible coverage option under the colorectal cancer screening benefit. However, under the Code of Federal Regulations (42 CFR 410.37(a)(1)(v)) at **http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr410_02.html** and the Social Security Act (section 1861(pp)(1)(D)) **http://www.ssa.gov/OP_Home/ssact/title18/1861.htm** on the internet), CMS is allowed to use the NCD process to determine coverage of other types of colorectal cancer screening tests not specifically identified in the law or regulations as it determines to be appropriate, and in consultation with appropriate organizations.

Following a request for reconsideration of the current NCD at Section 210.3 of the Medicare NCD Manual for colorectal cancer screening, CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test, as an alternative to a screening colonoscopy or a screening flexible sigmoidoscopy.

The FDA determined that this test is a medical device that requires pre-market review and approval prior to marketing, which, to date, has not been obtained. In the absence of an FDA determination, CMS believes that there may be unresolved questions regarding the safety and effectiveness of the stool DNA test. Therefore, CMS does not believe that identification of stool DNA mutations is an appropriate colorectal cancer screening test at this time.

Additional Information

The official instruction, CR 6145, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change, is reflected in two transmittals, one for the Medicare Benefit Policy Manual and one for the National Coverage Determinations Manual. These two transmittals are at **http://www.cms.hhs.gov/Transmittals/downloads/R93BP.pdf** and **http://www.cms.hhs.gov/Transmittals/downloads/R92NCD.pdf**, respectively, on the CMS website.

If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

CMS News Flash (GEN)

- The NPI will be Required for all HIPAA Standard Transactions on May 23rd. As of May 23, 2008, the NPI will be required for all HIPAA standard transactions. This means: For all primary and secondary provider fields, only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, DDE, 276/277, 270/271 and 835), paper claims (UB-04 and CMS-1500) and SPR remittance advice; and - Reporting of Medicare legacy identifiers in any primary or secondary provider fields will result in the rejection of the transaction.

- Medicare Remit Easy Print (MREP) software allows professional providers and suppliers to view and print the Health Insurance Portability and Accountability Act (HIPAA) compliant 835. This software, which is available for free can be used to access and print RA information, including special reports, from the HIPAA 835. Please go to your Carrier or DME MACs Web site to download the MREP software. To find your carrier or DME MACs Web address, see **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

- The Medicare Remit Easy Print brochure has been updated and is now available to order print copies or to download as a PDF file. This brochure provides an overview of free software that enables physicians and suppliers to view and print remittance information. To view the PDF file, go to **http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRemit_0408.pdf**. Print copies may be ordered by visiting the MLN Product Ordering Page at **http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5** on the CMS Web site.

- The Office of the Inspector General in the Department of Health and Human Services has issued a policy statement that assures Medicare providers, practitioners, and suppliers affected by retroactive increases in payment rates under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 that they will not be subject to OIG administrative sanctions if they waive retroactive beneficiary cost-sharing amounts attributable to those increased payment rates, subject to the conditions noted in the policy statement. To view the document, go to **http://oig.hhs.gov/fraud/docs/alertsandbulletins/2008/MIPPA_Policy_Statement.PDF** on the Internet.

The **Medicare Improvements for Patients and Providers Act of 2008**, which was enacted on July 15, 2008, has delayed the **Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program**.

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

The LCDs can be found on the DME MAC A Web site at:
http://www.medicarenhic.com/dme/medical_review/mr_index.shtml

LCDs can also be found on the CMS Web site within the Medicare Coverage Database (MCD), which is accessible by going to:
http://www.cms.hhs.gov/mcd/overview.asp

Blood Glucose Monitor Supplies - Utilization Requirements Reminder (SPE)

Recent data analysis for Jurisdiction A has revealed a number of beneficiaries have received supplies that exceed the policy's utilization amounts. The policy recognizes that there may be occasions when a beneficiary may require greater than expected amounts. This article is intended to serve as a reminder of the key policy elements.

The LCD divides utilization into 2 groups based upon type of treatment.

- Insulin treated group, indicated by the KX modifier, at 100 strips/lancets per month (300 per 3 months) and
- Non-insulin treated group, indicated with a KS modifier, at 100 strips/lancets per 3 months

These amounts represent the maximum amount that most beneficiaries will need based upon typical testing frequencies. For those who require additional amounts because of higher than usual testing frequency, the following additional requirements apply:

- The treating physician has ordered a frequency of testing that exceeds the utilization guidelines and has documented in the patient's medical record the specific reason for the additional materials for that particular patient.

- The treating physician has seen the patient and has evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets, or lens shield cartridges that exceed the utilization guidelines.

- If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

Remember that suppliers are obligated to monitor actual utilization.

"Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering physicians that the atypical utilization is, in fact, warranted."

To justify payment the LCD requires certain documentation.

- The order for home blood glucose monitors and/or diabetic testing supplies must include all of the following elements:
  1. The item(s) to be dispensed;
  2. The specific frequency of testing;
  3. The treating physician's signature;
  4. The date of the treating physician's signature;
  5. A start date of the order - only required if the start date is different than the signature date.

- An order that only states "as needed" will result in those items being denied as not medically necessary. A new order must be obtained when there is a change in the testing frequency.

- The ICD-9 diagnosis code describing the condition that necessitates glucose testing must be included on each claim for the monitor, accessories and supplies.

- Additional documentation requirements apply to: 1) a diabetic patient who is not insulin-treated (KS modifier present) and whose prescribed frequency of testing is more often than once per day, or 2) a diabetic patient who is insulin-treated (KX modifier present) and whose prescribed frequency of testing is more often than three times per day. When refills for quantities of supplies that exceed the utilization guidelines are dispensed, the documentation as described in criteria (d)-(f) in the Indications and Limitations of Coverage and/or Medical Necessity section must be available on request.

Refer to the *Glucose Monitors LCD* and the *Supplier Manual* for additional information.

Coding Instructions - Otto Bock C-Leg® (O&P)

Recently during a claim review, it was noted that suppliers were billing the miscellaneous code L5999 for two functions of the Otto Bock C-Leg® lower extremity prosthesis - "continuous gait assessment, computerized MKP prosthesis" and "electronically controlled static stance regulator, adjustable." This coding is not correct. The on-board, real-time gait analysis and stance regulation are accomplished by the microprocessors in the Otto Bock knee (code L5856). There is no separate billing and reimbursement for these functions since the allowance for these functions are included in the reimbursement for code L5856.

According to the SADMERC, the following are the only HCPCS codes billable for the Otto Bock C-Leg®:

L5828 Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control

L5845 Addition, endoskeletal knee-shin system, stance flexion feature, adjustable

L5848 Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability

L5856 Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type

L5920 Addition, endoskeletal system, above knee or hip disarticulation, alignable system

L5930 Addition, endoskeletal system, high activity knee control frame

L5950 Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)

Suppliers are reminded that for any questions regarding the correct coding of products to access the Durable Medical Equipment Coding System (DMECS) at **http://www3.palmettogba.com/dmecs/jsp/index.jsp** or contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Coding Helpline at 877-735-1326.

Remember that you can fax your immediate offset requests
http://www.medicarenhic.com/dme/forms/offsetrequest.pdf

Continuous Positive Airway Pressure System (CPAP) LCD - Revised (SPE)

The CPAP policy has been revised to reflect the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) on the use of home sleep tests to qualify patients with obstructive sleep apnea (OSA) for Positive Airway Pressure (PAP) devices. Certain provisions of the policy are effective for dates of service on or after March 13, 2008, the effective date of the NCD; however, certain requirements will be prospectively implemented for dates of service on or after September 1, 2008.

Since some LCD provisions have differing effective dates, the criteria that apply for coverage are dependent on the date the PAP device was dispensed. There are 3 critical dates:

1. If the PAP device was dispensed prior to March 13, 2008, the initial coverage criteria and coverage criteria for use beyond the first 3 months must meet the CPAP policy requirements that were effective January 1, 2008.

2. If the PAP device was dispensed after March 13, 2008 but before September 1, 2008, the initial coverage criteria and the criteria for coverage after the first 3 months must meet the requirements in this revised PAP policy that reflect the CMS NCD requirements outlined in CMS Internet-Only Manual Pub. 100-3, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4, Section 240.1.

3. If the PAP device is dispensed on or after September 1, 2008, all requirements in this revised PAP policy must be met.

If the PAP device was dispensed prior to September 1, 2008, the KX modifier may be added to the claim if:

1. The initial coverage criteria in effect at the time were met; and,
2. The criteria for coverage after the first 3 months that were in effect at the time were met; and,
3. The patient continues to compliantly use the device.

It should also be noted that the name of the policy has changed to Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea. The change reflects the addition of coverage criteria for respiratory assist devices (E0470 and E0471) when used to treat OSA. With the addition of these coverage criteria to the PAP policy, provisions related to the use of codes E0470 and E0471 for OSA were removed from the Respiratory Assist Device (RAD) policy. A revision of the RAD policy reflecting this change will be published in the near future.

Suppliers should review the entire PAP policy for additional information on the coding, coverage and documentation requirements for these devices.

Immunosuppressive Drugs LCD Revision - KX Modifier Requirement Added (DRU)

The Immunosuppressive Drugs LCD has been revised to include a requirement for the supplier to obtain the date of the qualifying transplant and affirm that the transplant date precedes the date of service for the immunosuppressive drug claim. If these criteria are met, the KX modifier must be added to the claim.

The Documentation requirements section of the LCD states,

> For claims received on or after July 1, 2008, the KX modifier must be added to the claim line(s) for the immunosuppressive drug(s) only if the supplier obtains from the ordering physician the date of the organ transplant and the transplant date precedes the date of service on the claim. If these requirements are not met, the KX modifier may not be added to the claim.

Please note that this requirement is effective for **claims received** on or after July 1, 2008. Refer to the LCD for additional information.

KX Modifier and the Knee Orthoses Local Coverage Determination (O&P)

Recently questions have arisen regarding the proper use of the KX modifier in the Knee Orthoses local coverage determination (LCD). This policy is effective for dates of service on or after July 1, 2008. The LCD requires the use of the KX modifier; however, suppliers have questioned to which codes the modifier should be applied.

The KX modifier should be appended to both the base knee orthosis code and any addition code(s) only if:

1. All the coverage criteria in the "Indications and Limitations of Coverage and or Medical Necessity" section of the Knee Orthoses LCD have been met; and,
2. Documentation is retained in the supplier's files.

This information must be available to the DME MAC or DME PSC upon request. If the requirements for the KX modifier are not met, the KX must not be used.

Suppliers may also access the Durable Medical Equipment Coding System (DMECS) at **http://www3.palmettogba.com/dmecs/jsp/index.jsp** or contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Coding Helpline at 1-877-735-1326 for questions regarding the correct coding of orthotic products.

Ostomy Supplies - Billing Clarification (SPE)

A review of claims for ostomy supplies by a Program Safeguard Contractor (PSC) has identified that unclear and/or incomplete physicians' written orders resulted in many claims denials.

Suppliers are reminded that they may dispense ostomy supplies based on a verbal or preliminary written order; however, they must have a detailed written order in their files before submitting a claim to Medicare. Verbal or preliminary written orders must contain, at a minimum:

- Beneficiary's name
- Description of the item
- Treating physician's name
- Start date of the order (if different from the physician's signature date)

Suppliers must maintain the preliminary written order or written documentation of the verbal order and this documentation must be available to the DME MACs or DME PSCs upon request. If the supplier does not have an order from the treating physician before dispensing an item, the item is non-covered.

For items that are dispensed based on a verbal order or preliminary written order, the supplier must obtain a detailed written order before submitting the claim.

For detailed written orders, the following elements must be present:

- Beneficiary's name
- Description of the item (either narrative or brand name/model number) including all options or additional features that will be separately billed or that will require an upgrade code
- Treating physician's name
- Start date of the order (if different from physician's signature date)

For ostomy supplies or any item that is dispensed on a periodic basis, the detailed written order must also include:

- Quantity to be dispensed
- Frequency of change
- Length or duration of treatment

Someone other than the physician may complete the detailed descriptions of the ostomy supplies; however, the treating physician must review the detailed descriptions and personally sign and date the order to indicate agreement.

The supplier must have a detailed written order prior to submitting a claim. If a supplier does not have a faxed, photocopied, electronic or pen and ink signed detailed written order in their records before they submit a claim to Medicare (i.e., if there is no order or only a verbal order), the claim will be denied.

A detailed written order may be a pre-printed form listing several ostomy supplies, ideally including the HCPCS code, but the specific supplies the beneficiary is using must be checked off. The treating physician must sign and date the form.

When the quantity of ostomy supplies billed is greater than the usual maximum quantity listed in the Indications and Limitations of Coverage and/or Medical Necessity section of the Ostomy Supplies local coverage determination (LCD), there must be clear, specific, and detailed documentation in the patient's medical records corroborating the medical necessity of amounts in excess of the LCD's parameters. General statements such as "change as needed" are not acceptable. Copies of the patient's medical records that corroborate the order and any additional documentation that pertains to the medical necessity of items and quantities billed must be available upon request.

More information regarding physician orders can be found in the *DME MAC Jurisdiction A Supplier Manual*, Chapter 10. Suppliers may also access the Durable Medical Equipment Coding System (DMECS) at **http://www3.palmettogba.com/dmecs/jsp/index.jsp** or contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Coding Helpline at 1-877-735-1326 for questions regarding the correct coding of ostomy products.

Policy Article Update for Ostomy Supplies- July 2008 Publication (SPE)

The Policy Article for Ostomy Supplies, effective 01/01/08 (July 2008 Publication), has been updated to add HCPCS code A5120 to the list that requires use of the AU modifier for payment when billing for ostomy supplies.

Refer to the LCD for Ostomy Supplies and the related Policy Article for additional information.

Positive Airway Pressure Devices LCD - Delayed Implementation (SPE)

In July, the DME MACs published a Local Coverage Determination (LCD) on Positive Airway Pressure (PAP) Devices for Obstructive Sleep Apnea. Some criteria in that policy were to take effect for dates of service on or after September 1. All criteria with a September 1, 2008 implementation date are being delayed. A revised LCD will be published in the near future and will include a new effective date for those criteria.

Join the NHIC, Corp. DME MAC A ListServe!
Visit **http://www.medicarenhic.com/dme/** and select
"ListServe Sign-Up"

Power Mobility Devices, FAQ - ATS/ATP Requirements (MOB)

The Power Mobility Devices (PMD) LCD states that wheelchairs, classified as Group 2 with a single or multiple power option, Group 3, Group 4, Group 5 and Push Rim Activated Power Assist for manual wheelchairs, must be provided by a supplier that employs a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and has direct, in-person involvement in the wheelchair selection for the patient. This requirement was published in November 2006 with a prospective implementation date for PMDs delivered on or after April 1, 2008.

This FAQ will refer to both ATP and ATS credentials as ATS.

1. Clarify "employ" as it relates to an ATS within this policy.

The ATS must be employed by a supplier in a full-time, part-time, or contracted capacity as is acceptable by state law. The ATS, if part-time or contracted, must be under the **direct control** of the supplier.

2. If a supplier has a part time or contracted ATS on staff, what type of special documentation would be needed in an audit to prove the credential?

A supplier must show that the employee was working under the supplier's control and guidance. The supplier should also be able to provide evidence of the ATS certification upon request.

3. Would a supplier be asked to provide employment records in an MR audit?

Yes, employment records, contracting agreements or credential records could be requested. These types of records do not need to be routinely submitted with a claim but must be available upon request.

4. In the draft Supplier Standards, CMS is proposing that a RESNA certified ATS be employed FULL-TIME by the supplier. Will the LCD be in conflict with proposed standards?

No, there would be no conflict between the proposed supplier standards and the DME MAC policy. The proposed supplier standards specify that the supplier must employ a full time ATS, but do not require that that individual have direct, in-person involvement with each patient. If that person did have direct involvement, that would satisfy the requirements of the DME MAC LCD. However, if the supplier wanted to hire **additional** part-time or contracted staff, that would meet the requirements of the LCD.

5. What does it mean for the ATS to have direct, in-person involvement in the wheelchair selection process?

It means to physically see and interact with the patient face-to-face (F2F). It is important that the record show how the ATS was involved and that medical personnel drove the process.

6. Can the ATS sign off on the licensed/certified medical professional (LCMP) evaluation, detailed product description or some other attestation to demonstrate compliance with the requirement or would an ATS/ATP log be appropriate?

The medical directors have not mandated how suppliers document compliance with the ATS/ATP requirement. **There must be evidence in the supplier's file of direct in-person interaction with the patient by the ATS in the wheelchair selection process.** Suppliers must document how the ATS is involved with the patient. The documentation must be complete and detailed enough so a third party would be able to understand the nature of the ATS involvement and to show that the standard was met. Just "signing off" on a form completed by another individual would not adequately document direct, in-person involvement.

7. If an ATS is involved, in person, at the time of the face-to-face (medical) assessment and communicates with the referring clinician during development of the specifications, does that meet the requirement?

Yes, the requirement would be met if the medical record documents their level of involvement. The ATS should also document this participation in a manner that can be verified in the event of an audit.

8. Must the supplier's ATS be present for the delivery, fitting, and/or patient training for the wheelchair provided?

The policy states the credentialed ATS must have direct, in-person involvement with equipment selection process. The policy does not require that the ATS be present for delivery, fitting, and/or patient training for the wheelchair.

9. A company employs an ATS, as well as a number of non-credentialed staff who have direct, in person involvement with the selection process. Is it permissible for the ATS to review the staff's recommendations and sign concurrence to meet the requirement?

Only a RESNA credentialed ATS who specializes in wheelchairs and who has direct in-person involvement with the wheelchair selection process may provide certain chairs as described in the PMD LCD as of 4/1/08. An ATS cannot simply "review" and "sign off" on non-credentialed staff work in order to meet the requirement.

10. If the ATS is not present at the face-to-face examination with the therapist or physiatrist, but does assess the patient "in person" prior to or following the evaluation by the LCMP, such as during the home evaluation, does this fulfill the requirement for "involvement with the selection process"?

If the ATS has direct contact with the patient and has taken part in the wheelchair selection process, the requirement is met, providing the ATS interaction is clearly documented within the patient's file. If the ATS has not had direct in-person involvement in the wheelchair selection process, and simply delivers the ordered product, the requirement is not met and the KX modifier must NOT be added to the code.

Since the purpose of the ATS role is to assure that the equipment selected is appropriate to address the medical needs identified during the F2F examination process, it would be inappropriate to begin product selection prior to completion of the F2F examination. Any in-person ATS/beneficiary interactions prior to the F2F examination would not be considered sufficient to meet the LCD requirement.

11. An ATS candidate has taken the RESNA exam but as of 4/1/08 has not yet received the credential. In the event of an audit, will the pending receipt of the ATS credential, retroactively dated to the day the test was taken, be considered compliant?

For a rehab power WC that is delivered on or after 4/1/08, there must have been an evaluation by a properly credentialed, supplier-employed ATS. The ATS must have been certified as of the date of he/she performed the in-person evaluation of the patient. The ATS is not a credentialed ATS until receipt of the credential from RESNA. RESNA document will specify the effective date of the credential.

- Example #1 - PT takes ATS exam on 3/1. PT evaluates patient on 3/15. PMD is delivered on 4/2. RESNA notifies PT on 4/15 that he/she passed exam and was credentialed as an ATP as of 3/1 (the date of the exam). If the supplier submits the claim prior to 4/15, then a KX modifier must not be used because the result of the credentialing exam was not yet known. However, if the supplier files the claim after 4/15, then the KX modifier may be added to the code (if all other criteria are also met).

- Example #2 - PT evaluates patient on 3/1. PT takes the exam on 3/15. Even if the PT is notified that he/she passed the exam and was credentialed as of 3/15, the KX modifier cannot be added to the claim line because the PT was not credentialed by RESNA as of the date of the evaluation (3/1).

12. Will a supplier, that does not have an ATS on staff as of 4/1/08, who provides a PMD requiring this credential, be in compliance with the LCD?

No. As outlined in the Power Mobility Devices LCD, claims for Group 2 SPO or MPO, Group 3, Group 4, Group 5 and push-rim activated power assist chairs with dates of service (DOS) on or after April 1, 2008, must meet the requirement that a RESNA certified ATS has direct in-person involvement in the wheelchair selection process. In this scenario, the wheelchair would not meet coverage criteria and a KX modifier must NOT be added to the code.

13. If an ATS employed by a supplier who has had direct in person involvement in the wheelchair selection process for a patient leaves a company before the wheelchair is delivered, will the claim be considered compliant?

Leaving the company employment would not invalidate what that person did while working as a RESNA certified ATS. The patient's record must illustrate the previously employed ATS had in-person involvement with the wheelchair selection process.

14. Can an ATP be involved in the face-to-face examination process, required for all PMDs, or the specialty evaluation required for rehab power wheelchairs also perform the functions of the ATS for the supplier of Group 2 SPO or MPO, Group 3, Group 4, Group 5 and push-rim activated power assist chairs?

For an ATP involved in the F2F examination or specialty evaluation process, it would be a conflict-of-interest to perform functions that meet the supplier requirements for an ATS to have direct in-person involvement in the Group 2 SPO or MPO, Group 3, Group 4, Group 5, and push-rim activated power assist chairs selection process.

15. Will the ATS have to do the evaluation in person, or can an evaluation be videotaped? Alternatively, if the ATS participated in the evaluation by means of a live video feed, would that be acceptable?

Review of a live video feed or videotaped "evaluation" would NOT meet the requirements of the policy. The "direct, in-person involvement" requirement means just that - a live, in-person, interaction between the ATS and the beneficiary addressing the selection of the actual equipment to be provided is required. The goal is to assure that the items selected are those that are most appropriate to address the beneficiary's needs. Remote or indirect interactions are not considered sufficient to meet the requirement.

Physician Letter: Intermittent Urinary Catheterization (SPE)

June 20, 2008

Dear Physician,

Recently Medicare changed the local coverage determination (LCD) for urological supplies. The previous policy covered "clean technique" for patients without a history of recurring urinary tract infections - allowing four intermittent catheters per month, which were cleaned and re-used. Now any patient who utilizes intermittent catheterization can receive one sterile urological catheter and one packet of lubricant for each catheterization.

Because of this change in Medicare policy, medical equipment suppliers may be contacting you for new prescriptions for your patients. There are a couple of important points to keep in mind. First, the prescription should reflect the actual number of times that the patient actually catheterizes him/herself per day. For example, if the patient self-catheterizes four times per day, the prescription should be for approximately 120 catheters per month. Although the LCD says that Medicare will cover up to 200 intermittent catheters per month, this is a maximum number and most patients self-catheterize less than 6 times per day. It would be inappropriate to order 200 catheters per month for every patient. The prescription must be individualized for each patient.

The second important point is that you should clearly document in your chart the number of times per day that the patient performs self-catheterization. Just listing that value on the prescription or on a separate form provided by the supplier is not sufficient. In the case of an audit, we would look for documentation in the patient's medical record.

Thank you for your cooperation and your care of Medicare beneficiaries.

Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A

Adrian M. Oleck, MD
Medical Director
DME MAC Jurisdiction B

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director
DME MAC Jurisdiction C

Robert F. Szczys, MD
Medical Director
DME MAC Jurisdiction D

Wheelchair Options and Accessories - Remote Joysticks and Controllers - FAQ (MOB)

Q. What is the correct coding when a standard proportional remote joystick is provided at the time of initial issue of a power wheelchair?

A. There is no separate billing for a standard proportional remote joystick when it is provided at the time of initial issue of a power wheelchair. Payment is included in the allowance for the power wheelchair base. If a nonexpandable controller is provided at the time of initial issue, payment is also included in the allowance for the wheelchair base and there is no separate billing.

If an expandable controller is provided at the time of initial issue, code E2377 (expandable controller) and E2313 (harness for upgrade to expandable controller) are separately billable and payable. If a power seating system is provided and if the system is controlled through the drive control interface, code E2310 or E2311 is used. There is no additional separate billing using code E2399 or K0108 for any components of a nonexpandable or an expandable controller.

Refer to the Coding Guidelines section of the Wheelchair Options and Accessories Policy Article for definitions of the components described above and additional coding information.

Be sure to visit the "What's New" section of our Web site at
http://www.medicarenhic.com/dme/dme_whats_new.shtml
for the latest information and updates regarding the Medicare program and DME MAC A.

Claim Submission for Items Requiring the EY Modifier - Instructions for COB Purposes (GEN)

CMS instituted modifier "EY" (no physician or other licensed health care provider order for this item or service) to allow DMEPOS suppliers to submit claims to Medicare for items or services that were provided without a dispensing order.

Effective for claims with dates of service on or after May 23, 2008, suppliers billing for DMEPOS items dispensed without a physician's order to secure a Medicare denial for COB purposes shall use the modifier "EY" and report their own name and NPI in the Ordering/Referring Provider Name fields of the claim. **If the supplier has obtained a physician's order for some, but not all, of the items provided to a particular beneficiary, the supplier must submit a separate claim for the items dispensed without a physician's order.**

To assure prompt processing of your claims affected by this issue, MM5771 instructs the following:

- The supplier's name should be reported in item 17 and the supplier's NPI in 17b of the CMS-1500 Claim Form, version 08-05; or
- The supplier's name and NPI should be reported in both the 2420E (ordering provider name) and 2420F (referring provider name) loops of the ASC X12N 837 professional claim format
- Make sure the "EY" modifier is present on each line item on the claim

Claims submitted incorrectly with a combination of ordered and non-ordered items will be denied as unprocessable. The Remittance Advice message reported on these denied claims is CO-4 (the procedure code is inconsistent with the modifier used or a required modifier is missing). In order to receive the appropriate denial for COB purposes, the claim must be corrected and resubmitted.

Clarification - Resubmission of Negative Advance Determination of Medicare Coverage (ADMC) Requests (MOB)

The DME MAC A has received several inquiries regarding confusion on the process of resubmitting negative ADMC requests.

Per the *CMS Program Integrity Manual* (Pub. 100-08, Chapter 5, Section 5.16.5), a negative ADMC decision communicates to the supplier and the beneficiary that, based on the information submitted with the request, the beneficiary does not meet the medical necessity requirements Medicare has established for the item. *A beneficiary or a supplier can resubmit an ADMC request if additional medical documentation is obtained that could affect the prior negative ADMC decision. However, requests may only be submitted once during a 6-month period.*

To clarify the above italicized statements, if the ADMC request for the wheelchair base is denied and the supplier obtains additional medical documentation, an ADMC request may be resubmitted. **ADMC requests may only be resubmitted once during the six-month period following a negative determination.**

Note: Since a negative ADMC determination does not meet the regulatory definition of an initial determination because no request for payment is being made, it may not be appealed.

Refer to Chapter 10 of the *DME MAC A Supplier Manual* for additional information on the ADMC process.

Second Quarter 2008 - Top Claim Submission Errors (GEN)

A claim submission error (CSEs) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for April through June 2008, are provided in the following table.

Top Ten Claims Submission Errors	Number Received	Reason For Error
20359 - Ordering Provider Secondary ID Invalid	217,352	The ordering provider secondary ID is invalid in the 2420E REF01 loop.
40014 - Ordering Provider Information Missing	99,185	The ordering provider information is missing in the 2420E NM108 loop.
40022 - Procedure Code/Modifier Invalid	44,430	The procedure code and/or modifier used on this line is invalid.
20364 - Rendering Provider Secondary ID Invalid	20,643	The rendering provider secondary ID is invalid in the 2310B REF01 loop.
40068 - Invalid/Unnecessary CMN Question	13,008	The question number entered is not valid for the DME MAC CMN you are sending.
20269 - Pointer 1 Diagnosis Invalid	12,347	Diagnosis pointer is invalid in first diagnosis field.
20143 - Ordering Provider Secondary ID Invalid	10,925	The secondary National Provider Identifier (NPI) is invalid in the 2420E REF02 loop.
20352 - Referring Provider Secondary ID Invalid	10,831	The referring provider secondary ID is invalid in the 2310A REF01 loop.
40073 - Dates of Service Invalid with Procedure Code	9,023	The procedure code used is not valid for the dates of service used.
20110 - Procedure Code Invalid	7,806	Procedure code is invalid or discontinued.

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the second quarter of 2008. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed, however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from April through June 2008.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 16 N280 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid pay to provider primary identifier.	**Item 33** - NPI bypass logic rejection - Invalid NPI/PTAN (National Provider Identifier/Provider Transaction Access Number) pair on the crosswalk file.	9,247
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	4,727
CO 16 MA130 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only)	4,566
CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	3,386

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure codes(s) and/or rates.	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	2,655
CO 16, CO 207 N265 N286 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid ordering provider primary identifier.	**Item 17** - Enter the name of the referring or ordering physician, if the service or item was ordered or referred by a physician.	2,028
CO 16 M51, N225 N29 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or dates. Missing / incomplete / invalid documentation.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). NOC (Not Otherwise Classified) codes billed and a narrative description was not entered.	1,011
CO 16 M76, M81 You are required to code to the highest level of specificity. Missing / incomplete / invalid diagnosis or condition.	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity.	559
CO 16 M77 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid place of service.	**Item 24B** - Invalid place of service submitted. Must indicate place of service where the equipment/supplies will be used.	237
CO 16 M119 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid / deactivated / withdrawn National Drug Code (NDC).	**Item 24D** - Enter a valid National Drug Code (NDC).	200

Make it a goal to reduce the number of CSEs by taking the extra time to review your claims before submission to ensure that all the required information is on each claim. DME MAC Jurisdiction A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency. Please take advantage of the information in the above tables and share it with your colleagues.

DME MACS to Attend the 2008 AOPA National Assembly and Fall Medtrade (GEN)

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and the National Supplier Clearinghouse (NSC) will partner to attend the American Orthotic and Prosthetic Association (AOPA) National Assembly at the Hyatt Regency in Chicago, IL held September 10-13, 2008 and the Medtrade Conference and Expo (**Booth # 2338**) at the Georgia World Congress Convention Center to be held October 27-30, 2008.

The contractors will share booth space and also provide presentations. This joint effort by the DME MACs and the NSC gives the supplier community an opportunity to interact directly with these contractors in one location.

For event details, please visit the "Events and Seminars" section of the DME MAC A Web site at: **http://www.medicarenhic.com/dme/dmerc_seminars.shtml**.

Reminder - VPIQ Password Requirements (GEN)

DME MAC A has received many inquiries regarding the password requirements for the VIPS Provider Inquiry System (VPIQ). The password for VPIQ must be six letters and two numbers and is not case sensitive. The password should not include any symbols or special characters. An acceptable password example is: SUMMER00. The password must be changed every 30 days. If a password has been revoked, please call **866-563-0049** for a password re-set. For additional information on VPIQ, please visit the VPIQ section of the DME MAC A Web site at: **http://www.medicarenhic.com/dme/vpiq.shtml**

Revised ABN Form - Mandated for Use March 1, 2009 (GEN)

Effective March 3, 2008, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131). The revised ABN replaces the existing ABN-G (Form CMS-R-131G), ABN-L (Form CMS-R-131L), and NEMB (Form CMS-20007)

CMS is providing a 1 year transition period from the date of implementation for use of the revised form and instructions, which permits the use of both the old version and the newly revised version.

Effective March 1, 2009, the transition period will end and all suppliers must begin to use only the new ABN form (CMS-R-131). The form and notice instructions are posted on the Beneficiary Notice Initiative Web page at **http://www.cms.hhs.gov/bni**

The DME MAC A Outreach & Education Team will be conducting Webinar sessions on the use of this revised form. Visit the *Events & Education* section of the Web site for dates and times of these sessions.

Spring 2008 Educational Seminars in Retrospect (GEN)

The Jurisdiction A DME MAC Outreach & Education Team completed a very successful round of seminars during the spring of 2008. A total of 48 seminars were conducted throughout Jurisdiction A. Topics included DME MAC A Billing Essentials, What's New with the Medicare Program-Keeping Up with DME MAC Changes, Nebulizers, Continuous Positive Airway Pressure (CPAP) Systems and Respiratory Assist Devices (RAD), Medicare Coverage of Non-Powered Mobility Assistive Equipment (MAE), and Medicare Coverage of Power Mobility Devices (PMDs). Attendees registered for each session via our online registration process and seminar materials were provided in advance via the "Events & Seminars" section of the DME MAC A Web site at: **http://www.medicarenhic.com/dme/dmerc_seminars.shtml**. Archived seminar materials can be retrieved via the "Outreach Materials" section of the Web site at: **http://www.medicarenhic.com/dme/dmeduc_seminars.shtml**.

Seminar attendees were asked to complete an evaluation form at the end of each educational session to include rating their overall satisfaction. This round of seminars achieved an overall satisfaction rating of 97% at exceeded/met expectations. In addition, participant comments included:

"Excellent Class!"
"Very helpful. Filled in a lot of gaps in my knowledge"
"I always learn something when I go to these seminars"
"Knowledgeable, professional, clear and concise. Overall, good job."
"Very informational and thorough seminar"
"Great job and a nice refresher. A lot of changes that allowed for discussion and questions"

The evaluation results have also been compiled into a comprehensive data package, for internal review of opportunities for improvement with future seminars and for areas where training may be needed to strengthen the skills of the Outreach Specialists. The entire Outreach & Education Team would like to thank all of the attendees for their enthusiastic participation, and we look forward to seeing you in the future.

Educational seminars are only one of the avenues used by Outreach & Education for the dissemination of information about the Medicare program. We also participate in numerous state and national outreach events, giving us the opportunity to partner with colleagues and reach a broader spectrum of the provider community. Providers should check the "Events & Seminars" section of our Web site, at **http://www.medicarenhic.com/dme/dmerc_seminars.shtml**, for announcements and schedules of upcoming seminars, Webinars and other outreach events.

Upcoming Quarterly Ask-the-Contractor Teleconference (ACT) Call (GEN)

The DME MAC A Outreach & Education Team will be conducting our quarterly ACT calls on Thursday, September 25th 2008. There will be two separate sessions discussing the newly revised Advance Beneficiary Notice (ABN). We will begin promptly at 10am EST and 2pm EST. Each session is scheduled to last approximately one hour. For additional information including session materials, visit the ACT page of the DME MAC A Web site at **http://www.medicarenhic.com/dme/dme_act.shtml**

DME MAC A Webinar Schedule Announcement (GEN)

The DME MAC Jurisdiction A Outreach & Education Team is excited to release the schedule for our Summer/Fall educational Webinars. The topics for this round of sessions will include: DME MAC Essentials I & II, Advance Beneficiary Notice (ABN), Enteral Nutrition Billing, Glucose Monitor Billing, Positive Airway Pressure (PAP) Devices and Respiratory Assist Devices (RAD), Pressure Reducing Support Surface Billing (Group 1 - Group 3), and Suction Pump Billing. For further details, including the schedule of these upcoming sessions, visit the "Events/Seminars" section of the DME MAC Jurisdiction A Web site at **http://www.medicarenhic.com/dme/dmerc_seminars.shtml**

Supplier Manual News (GEN)

The 2007 Edition of the *Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Supplier Manual* is available via the "Publications" section of our Web site at **http://www.medicarenhic.com/dme/dme_publications.shtml**. After accepting the CPT License Agreement, suppliers can access the entire *DME MAC A Supplier Manual*, including revised chapters and archived revisions. The 2008 Edition is available to current suppliers via the DME MAC A Web site only, and newly-enrolled suppliers will continue to receive initial hard copy manuals, as mandated by the Centers for Medicare & Medicaid Services (CMS). The option to request additional copies for a fee is not available to anyone at this time.

Updates/Corrections Made:
In July of 2008 **all chapters** of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. In order to avoid potential viewing and/or printing problems, be sure to follow the download instructions to access the revised pages.

DME MAC A ListServes (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) ListServes are used to notify subscribers via email of important and time-sensitive Medicare program information and other important announcements or messages. All you need is Internet access and an email address.

What are the benefits of joining the DME MAC A ListServes? By joining, you will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly *Bulletins* and *Supplier Manual* revisions become available on our Web site. Additionally, there are specialty/areas of interest ListServes that enable DME MAC A to send targeted information to specific supplier/provider audiences when the information is posted on our Web site. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

Signing up for the DME MAC A ListServes gives you immediate email notification of important information on Medicare changes impacting your business. Subscribe today by visiting the DME MAC A Web site at: **http://www.medicarenhic.com/dme/**

Quarterly Provider Update (GEN)

The Quarterly Provider Update (QPU) is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The QPU can be accessed at **http://www.cms.hhs.gov/QuarterlyProviderUpdates/**. CMS encourages you to bookmark this Web site and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the QPU Listserve at: **https://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1**

Please be sure that you have the most updated version of the IVR Guide and IVR Call Flow in your office, both can be found at: **http://www.medicarenhic.com/dme/contacts.shtml**

The Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) for Jurisdiction A will continue to offer our quarterly bulletin, the *DME MAC Jurisdiction A Resource*, in electronic format via our Web site, where copies can be printed free of charge. To access the bulletin, go to the "Publications" section of the DME MAC A Web site at ***http://www.medicarenhic.com/dme/dme_publications.shtml***. To be notified via email when bulletins are posted on our Web site, as well as the latest Medicare updates, subscribe to the DME MAC A ListServes, our electronic mailing lists. To subscribe, visit ***http://www.medicarenhic.com/dme/*** and click on "**Join the DME MAC A ListServe**".

For Suppliers without Internet Access: If you do not have Internet access and require the bulletin via hardcopy or CD-ROM*, you may subscribe to it for a fee. The annual subscription fee is $65.00 for hardcopy and $172.00 for CD-ROM. ***This subscription includes the four quarterly bulletins published during the calendar year of 2009 - March, June, September, and December.*** Complete this form and submit with payment, via check only, to the address listed below.

* The CD-ROM version of the bulletin is a Portable Document Format (PDF) file. To view PDFs, you must have Adobe® Acrobat® Reader® installed on your computer.

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Cash Accounting / DME Subscription
75 Sgt William B Terry Drive
Hingham, MA 02043

Signature: _____ Date: _____

For Your Notes

For Your Notes

Customer Service Telephone

Interactive Voice Response (IVR) System: 866-419-9458
Customer Service Representatives: 866-590-6731
TTY-TDD: 888-897-7539

Outreach & Education

781-741-3950

Claims Submissions

DME - Drug Claims
P.O. Box 9145
Hingham, MA 02043-9145

DME - Mobility/Support Surfaces Claims
P.O. Box 9147
Hingham, MA 02043-9147

DME - Oxygen Claims
P.O. Box 9148
Hingham, MA 02043-9148

DME - PEN Claims
P.O. Box 9149
Hingham, MA 02043-9149

DME - Specialty Claims
P.O. Box 9165
Hingham, MA 02043-9165

DME - ADS
P.O. Box 9170
Hingham, MA 02043-9170

Written Inquiries

DME - Written Inquiries
P.O. Box 9146
Hingham, MA 02043-9146

Written Inquiry FAX: 781-741-3118

DME - MSP Correspondence
P.O. Box 9175
Hingham, MA 02043-9175

Overpayments

Refund Checks:
DME - Accounting (Refund Checks)
P.O. Box 9143
Hingham, MA 02043-9143

Payment Offset Fax Requests: 781-741-3916

Note: I*nclude both the demand letter or the remittance indicating the overpayment, and the Offset Request Form*

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Faxed Reopenings: 781-741-3914

Redeterminations:
DME - Redeterminations
P.O. Box 9150
Hingham, MA 02043-9150

Redetermination For Overnight Mailings:
NHIC, Corp. DME MAC Jurisdiction A
Appeals
75 William Terry Drive
Hingham, MA 02044

Redetermination Requests Fax: 781-741-3118

Reconsiderations:
RiverTrust Solutions, Inc.
P.O. Box 180208
Chattanooga, TN 37401-7208

Reconsiderations For Overnight Deliveries:
RiverTrust Solutions, Inc.
801 Pine Street
Chattanooga, TN 37402

Administrative Law Judge (ALJ) Hearings:
HHS OMHA Mid-West Field Office
BP Tower, Suite 1300
200 Public Square
Cleveland, OH 44114-2316

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@EXAMHUB.exch.eds.com

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

LCD Reconsiderations Email Address:
NHICDMELCDRecon@examhub.exch.eds.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

NHIC, Corp.
Attention: ADMC
P.O. Box 9170
Hingham, MA 02043-9170

ADMC Requests Fax:

Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: ngs.CEDIHelpdesk@wellpoint.com

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INFORMATION for DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI & VT

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Visit the following Web sites for more information:

- NHIC, Corp.: www.medicarenhic.com/dme/
- TriCenturion: www.tricenturion.com
- CMS: www.cms.hhs.gov/

The *DME MAC Jurisdiction A Resource*, together with occasional special releases, serves as legal notice to physicians and suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

If you have any comments about the *DME MAC Jurisdiction A Resource* or would like to make suggestions, please write to:

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A CMS Contractor

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